First Health Services Corporation
A Coventry Health Care Company

Assessment Processing

VaMMIS Procedure Manual

Version 1.0

June 11, 2008

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	02/01/2008	[redacted], Documentation Mgmt. Team	Creation of document

Table of Contents

Preface

The Procedures Manual for the Virginia Medicaid Management Information System (VaMMIS) is a product of First Health Services Corporation. Individual manuals comprise the series of documents developed for the operational areas of the VaMMIS project. Each document includes an introduction, a functional overview of the operations area, workflow diagrams illustrating the processing required to accomplish each task, and descriptions of relevant inputs and outputs. Where appropriate, decision tables, lists, equipment operating instructions, etc. are presented as exhibits, which can be photocopied and posted at unit workstations. Relevant appendices containing information too complex and/or lengthy to be presented within a document section are included at the end of the document.

Use and Maintenance of this Manual

The procedures contained in this manual define day-to-day tasks and activities for the specified operations area(s). These procedures are based on First Health's basic MMIS Operating System modified by the specific constraints and requirements of the Virginia MMIS operating environment. They can be used for training as well as a source of reference for resolution of daily problems and issues encountered.

The unit manager is responsible for maintaining the manual such that its contents are current and useful at all times. A hardcopy of the manual is retained in the unit for reference and documentation purposes. The manual is also available on-line for quick reference, and users are encouraged to use the on-line manual. Both management and supervisory staff are responsible for ensuring that all operating personnel adhere to the policies and procedures outlined in this manual.

Manual Revisions

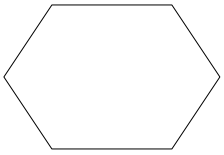
The unit manager and supervisory staff review the manual once each quarter. Review results are recorded on the Manual Review and Update Log maintained in this section of the document. Based on this review, the unit manager and supervisory staff determine what changes, if any, are necessary. The unit manager makes revisions as applicable, and submits them to the Executive Account Manager for review and approval. All changes must be approved by the Executive Account Manager prior to insertion in the manual. When the changes have been approved, the changes are incorporated into the on-line manual. Revised material will be noted as such to the left of the affected section of the documentation, and the effective date of the change will appear directly below. A hardcopy of the revised pages are inserted into the unit manual, and copies of the revised pages are forwarded to all personnel listed on the Manual Distribution List maintained in this section of the manual.

Flowchart Standards

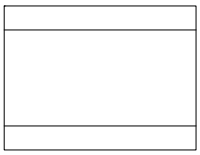
The workflow diagrams included in this document were generated through the flowcharting software product Visio Professional. Descriptions of the basic flowcharting symbols used in the VaMMIS documentation are presented below.

Large Processing Function

Manual Process. No automated processes are used; e.g., clerical function.

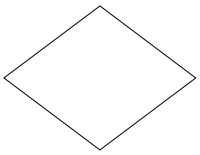


Data Preparation Processing; e.g., mailroom, computer operations, etc.

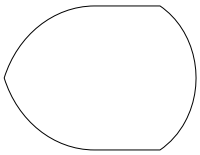


Create a Request

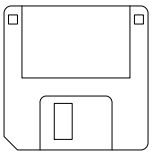
Data maintained in a master datastore.



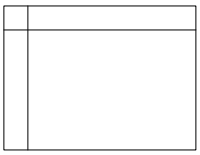
Decision



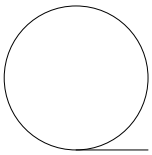
Information entered or displayed on-line.



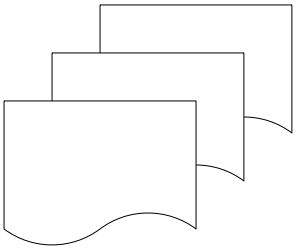
Data stored on diskette media.



On-line Storage; e.g., CD-ROM, microform, imaged data, etc.

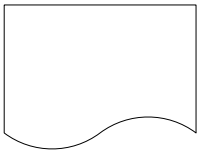


Input or Output Tape



Multiple Outputs; e.g., letters, reports

Communication Link



Single Output; e.g., letter, report, form, etc.

External Entity. Source of entry or exit from a process.

Off-page Connector

1.0 Overview of the Virginia Medical Assistance Program

The Commonwealth of Virginia State Plan under Title XIX of the Social Security Act sets forth the Commonwealth's plan for managing the Virginia Medical Assistance Program (VMAP). It defines and describes the provisions for: administration of Medical Assistance services; covered groups and agencies responsible for eligibility determination; conditions of and requirements for eligibility; the amount, duration, and scope of services; the standards established and methods used for utilization control, the methods and standards for establishing payments, procedures for eligibility appeals; and waivered services.

1.1 Standard Abbreviations for Subsystem Components

For brevity, subsystem components will use these abbreviations as part of their nomenclature.

Abbreviation	Subsystem
AM	Automated Mailing
AS	Assessment (Financial Subsystem)
CP	Claims Processing
DA	Drug Application
EP	EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
FN	Financial Subsystem
MC	Managed Care (Financial Subsystem)
MR	MARs (Management and Reporting)
POS	Point of Sale (Drug Application)
PS	Provider
RF	Reference
RS	Recipient
SU	SURS (Surveillance Utilization and Review)
TP	TPL (Financial Subsystem)

1.2 Covered Services

The Virginia Medical Assistance Program covers all services required by Federal legislation and provides certain optional benefits, as well. Services are offered to Medicaid Categorically Needy and Medically Needy clients. In addition, certain services are provided to eligibles of the State and Local Hospitalization (SLH) program and the Indigent Health Care (IHC) Trust Fund. SLH, Temporary Detention Orders (TDO), and IHC are State and locally funded programs with no Federal matching funds. SLH is a program for persons who are poor, but not eligible for Medicaid in Virginia, which is funded by the Commonwealth and local counties.

Services and supplies that are reimbursable under Medicaid include, but are not limited to:

- Inpatient acute hospital
- Outpatient hospital
- Inpatient mental health
- Nursing facility
- Skilled nursing facility (SNF) for patients under 21 years of age
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Hospice
- Physician
- Pharmacy
- Laboratory and X-ray
- Clinic
- Community mental health
- Dental
- Podiatry
- Nurse practitioner
- Nurse midwife
- Optometry
- Home health
- Durable medical equipment (DME)
- Medical supplies
- Medical transportation
- Ambulatory surgical center.

Many of the services provided by DMAS require a co-payment to be paid by the recipient. This payment differs by type of service being billed, according to the State Plan. Payment made to providers is the net of this amount.

General exclusions from the Medicaid Program benefits include all services, which are experimental in nature, cosmetic procedures, acupuncture, autopsy examination, and missed appointments. In addition, there are benefit limitations for specific service categories that must be enforced during payment request processing.

1.3 Waivers and Special Programs

In addition to the standard Medicaid benefit package, the Commonwealth has several Federal waivers in effect which provide additional services not ordinarily covered by Medicaid, as well as special programs for pregnant women and poor children. The programs include:

- **Elderly and Disabled** is a Home and Community Based Care (HCBC) waiver program covering individuals who meet the nursing facility level-of-care criteria and who are at risk for institutionalization. In order to forestall institutional placement, coverage is provided for:
  - Personal Care (implemented 1982)
  - Adult Day Health Care (implemented 1989)
  - Respite Care (implemented 1989)
- **Technology Assisted Waiver for Ventilator Dependent Children** is a HCBC waiver implemented in 1988 to provide in-home care for persons under 21, who are dependent upon technological support and need substantial ongoing nursing care, and would otherwise require hospitalization. The program has since been expanded to provide services to individuals over age 21.
- **Mental Retardation Waiver** includes two HCBC waivers that were implemented in 1991 for the provision of home and community based care to mentally retarded clients. They include an OBRA waiver for persons coming from a nursing facility who would otherwise be placed in an ICF/MR, and a community waiver for persons coming from an ICF/MR or community. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) updates the eligibility file for Mental Retardation Waivers.
- **AIDS/HIV Waiver** is a HCBC waiver implemented in 1991 that provides for home and community based care to individuals with AIDS, or who are HIV positive, and at risk for institutionalization.
- **Assisted Living Services** include two levels of payment, regular and intensive. Regular assisted living payments (per day per eligible recipient) are made from state funds. Intensive assisted living payments (per day per eligible recipient) are covered under an HCBC waiver and are made from a combination of state and federal funds.
- **Adult Care Resident Annual Reassessment and Targeted Case Management** provides for re-authorization and/or follow-up for individuals residing in assisted living facilities. The program includes a short assessment process for individuals who are assessed at the residential level, and a full assessment for individuals who are assessed at the regular or intensive assisted living level. The targeted case management is provided to individuals who need assistance with the coordination of services at a level which exceeds that provided by the facility staff.

- **PACE/Pre-PACE Programs** provide coordination and continuity of preventive health services and other medical care, including acute care, long term care and emergency care under a capitated rate.
- **Consumer-Directed Personal Attendant Services** is a HCBC waiver that serves individuals who are in need of a cost-effective alternative to nursing facility placement and who have the cognitive ability to manage their own care and caregiver.
- **MEDALLION Managed Care Waiver** is a primary care physician case management program. Each recipient is assigned a primary care physician who is responsible for managing all patient care, provides primary care, and makes referrals. The primary care physician receives fees for the services provided plus a monthly case management fee per patient.
- **MEDALLION II Managed Care Waiver** is a fully capitated, mandatory managed care program operating in various regions of the State. Recipients choose among participating HMOs, which provide all medical care, with a few exceptions.
- ***Options*** is an alternative to MEDALLION where services are provided through network providers, and the participating HMOs receive a monthly rate based on estimated Medicaid expenditures.
- **Client Medical Management (CMM)** is the recipient "lock-in" program for recipients who have been identified as over utilizing services or otherwise abusing the Program. These recipients may be restricted to specific physicians and pharmacies. A provider who is not the designated physician or pharmacy can be reimbursed for services only in case of an emergency, written referral from the designated physician, or other services not included with CMM restrictions. The need for continued monitoring is reviewed every eighteen (18) months.

  The services not applicable to CMM are renal dialysis, routine vision care, Baby Care, waivers, mental health services, and prosthetics.

- **Baby Care Program** provides case management, prenatal group patient education, nutrition counseling services, and homemaker services for pregnant women, and care coordination for high risk pregnant women and infants up to age two.

1.4 Eligibility

Medicaid services are to be provided by eligible providers to eligible recipients. Eligible recipients are those who have applied for and have been determined to meet the income and other requirements for the Department of Medical Assistance Services (DMAS) services under Medicaid. Virginia also allows certain Social Security Income (SSI) recipients to "spend down" their income to Medicaid eligibility levels by making periodic payments to providers.

Virginia is a Section 209(b) state, meaning that the DMAS administers Medicaid eligibility for SSI eligibles and State supplement recipients locally through the Department of Social Services (DSS). DSS administers eligibility determination at its local offices and is responsible for determining Medicaid eligibility of Temporary Assistance to Needy Families with Children (TANF), Low-Income Families with Children (LIFC), and the aged. DSS also determines financial eligibility of blind and disabled applicants. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) administers recipient eligibility for Mental Retardation Waivers. The Department of Visually Handicapped (DVH) and the Department of Rehabilitative Services (DRS) are responsible for determining the degree of blindness of an applicant and the determination of medical necessity, respectively.

Three categories of individuals are eligible for services under the VMAP: Mandatory Categorically Needy, Optionally Categorically Needy, and Optionally Medically Needy. In addition, DMAS operates two other indigent healthcare financing programs, the State and Local Hospitalization (SLH) and the Indigent Health Care (IHC) Trust Fund.

1.5 Eligible Providers and Reimbursement

Qualified providers enroll with the VMAP by executing a participation agreement with the DMAS prior to billing for any services provided to Medicaid eligibles. Providers must adhere to the conditions of participation outlined in the individual provider agreement. To be reimbursed for services, providers must be approved by the Commonwealth and be carried on the Provider Master File in the MMIS.

DMAS employs a variety of reimbursement methodologies for payment of provider services. Inpatient hospital and long-term care facilities are reimbursed on a per diem prospective rate, which goes into effect up to 180 days after the beginning of the rate period to allow for retroactive payment adjustments. Settlement is based on a blend of the per diem rate and the APG/DRG Grouper reimbursement methodology. Other providers are reimbursed on a fee-for-service (FFS) basis according to a Geographic Fee File maximum amount allowed. In the FFS methodology, payment is the allowed amount, or the charge, whichever is less; payment is adjusted by co-payment, as well as by any third-party payment. Medicare co-insurance and deductibles received in the crossover system are reduced to the Medicaid allowance when the Medicare payment and the Medicaid co-insurance amount would exceed the Medicaid-allowed amount. In addition to these payment methodologies, the MEDALLION managed care program uses case management fees as well as FSS. MEDALLION II is fully capitated and uses a per member, per month, payment methodology. Health maintenance organizations (HMOs) participating in the *Options* program are paid a monthly rate based on estimated Medicaid expenditures. Monthly fees are also paid for Client Medical Management (CMM).

2.0 Assessment Processing

The Virginia MMIS Data Entry Unit, Assessment Processing Section:

- Keys assessments:
  - Short Assessments
  - Full Assessments
  - Medicaid HIV Waiver pre-screening assessment/Plan of Care
  - Maternity Risk Screen
  - Infant Risk Screen
  - Maternal and Infant Care Coordination (MICC)
- Verifies keyed forms
- Refers problem forms to DMAS
- Sends Assessment TAD (cover letter) with assessments back to providers.
- Keys returned Assessment TADs
- Maintains detailed documentation of keying instructions for all DMAS forms
- Provides reports of data entry volumes and types of transactions with daily, weekly, and monthly summaries
- Accesses & reviews reports through OnDemand applications
- Accesses & reviews audit trail reports through CA Analyzer

3.0 Keying Assessment Forms

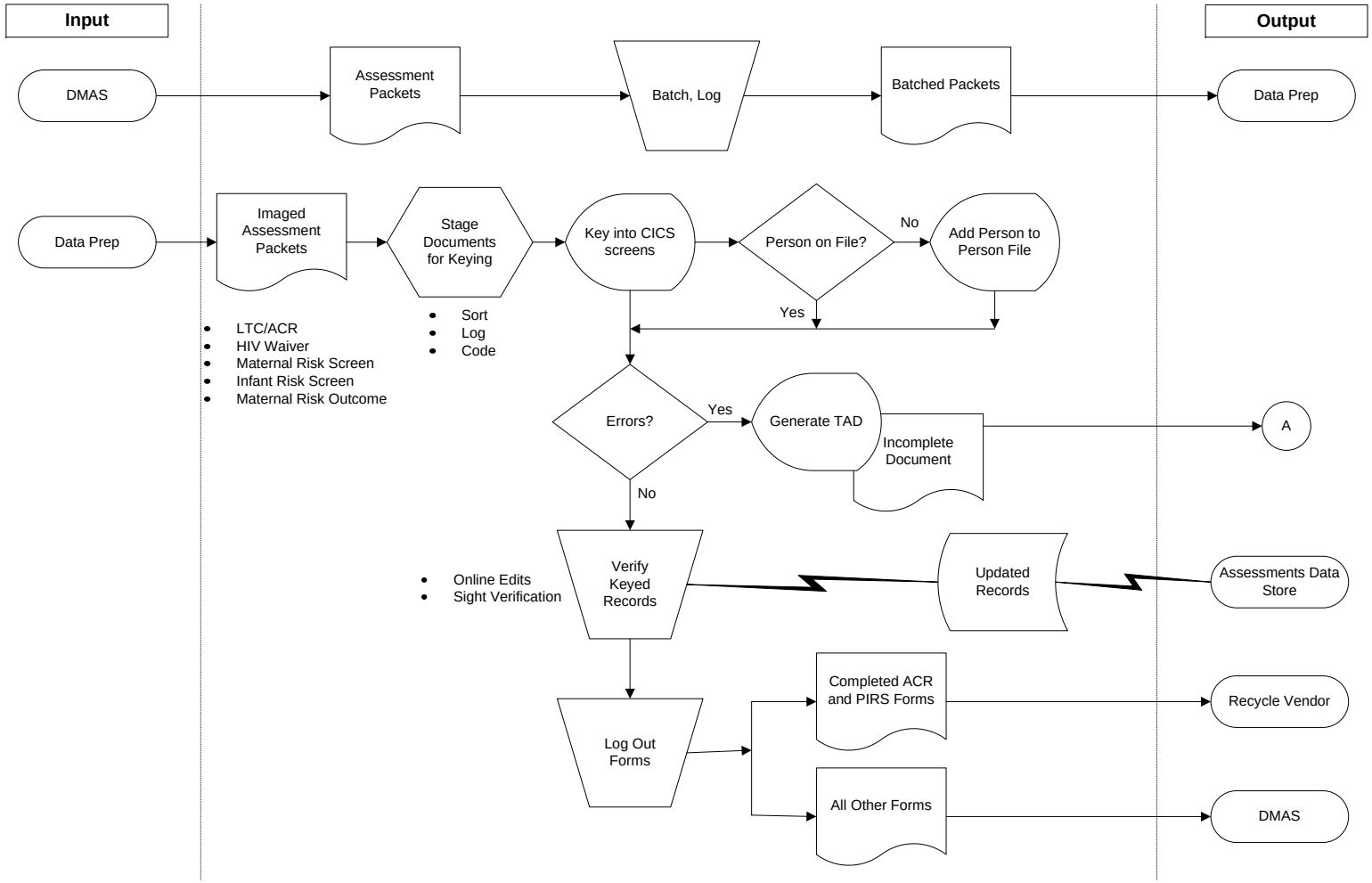
The Assessment Processing staff of the Data Entry Unit is responsible for keying all Assessment Packets into the appropriate MMIS screens. These include the following forms and their corresponding screens:

Assessment Packet	Screen
Medicaid Funded Long Term Care Service Authorization – DMAS 96 (AS-I-060)	AS-S-015
Virginia Uniform Assessment Instrument (AS-I-090)	AS-S-020
	AS-S-025
	AS-S-030
	AS-S-035
	AS-S-040
Medicaid HIV Waiver Pre-Screening Assessment – DMAS 113A (AS-I-020)	AS-S-040
Medicaid HIV Waiver Services Pre-Screening Plan of Care – DMAS 113B (AS-I-030)	
Maternity Risk Screen DMAS 16 (MI-I-001)	MI-S-005
Maternal and Infant Care Coordination Record DMAS 50 (MI-I-003)	MI-S-006
Infant Risk Screen - DMAS 17 (MI-I-002)	MI-S-002
Maternal and Infant Care Coordination Record DMAS 50 (MI-I-003)	MI-S-003
MICC Infant Outcome Report – DMAS 52	MI-S-004
MICC Pregnancy Outcome Report – DMAS 53	MI-S-007

Samples of the Assessment Forms can be found in Appendix A - Assessment Forms.

WORKFLOW PROCESS

Keying Assessment Forms



3.1 Receiving/Staging Assessment Packets

The Data Prep Unit will image Assessment documents before they are keyed. Any Assessment packets received from DMAS are logged and batched, then routed to Data Prep to be imaged. All hard-copy Assessment packets will be routed to Assessment Processing staff after they have have been imaged. The Assessment Processing staff will stage the packets for keying.

Procedure

1. Receive assessments from data prep.
2. Put batches on table in type order. (Assessments, Maternity Risk and Infant Risk).
3. Distribute to Assessment Processing operators as work is needed.

3.2 Enrollee Not on File

Assessment forms cannot be entered into the MMIS unless the person being screened is on the MMIS Person File and is active on the screening date. For assessments that screen persons for the purpose of determining eligibility, it is likely that the person is not already on file and active. If you are attempting to key an assessment form and the system states the person is not on file, you will need to set aside the assessment and add the person to the enrollment file before entering the assessment.

Procedure

1. If enrollee is not on file, indicate with an *E* at the top of the assessment and circle it.
2. Set all enrollees not on file in their own stack.
3. Collect all assessments at the end of the day.
4. Give an operator the assessments that need to be enrolled. See instructions in Section 4.3.
5. After the recipient has been added, enter assessment into the system.

3.3 Assessments with Missing or Invalid Information

The MMIS will allow entry of assessments with missing or invalid data. If you accept/update the record with errors, the system will place the record in pending status and generate a Turnaround Document (TAD) cover letter that will print the following day. The assessment form is then attached to the cover letter and returned to the provider for correction. After you accept the incomplete, pended assessment record, you will need to place the document face down in a separate stack to wait for the cover letter to print.

Procedure

1. If the assessment had any errors, indicate at the top of the document with a *T* and circle. You will know whether the assessment had errors because the screen will show *Pended* instead of *Approved* or *Denied* in the **Assessment Status** field.
2. Type a series of asterisks in the fields with invalid or missing data.
3. Set all assessments with errors aside face down in their own stack (keep them in ACN order).
4. Collect all errors (TADS) at the end of the day.
5. See Section 4.2.1 for processing outgoing TADS.

3.4 Patient Intensity Rating Screen (PIRS)

This is the DMAS 80 form. DMAS has taken over responsibility for keying this form.

Procedure

Should a PIRS form be received in the Assessments Processing Unit, forward the form to Melissa Fritzman at DMAS.

3.5 DMAS-96 and Uniform Assessment Instrument (UAI) – Short Assessment

This packet includes the DMAS 96 form and the UAI form. The packet is keyed using the following MMIS on-line screens:

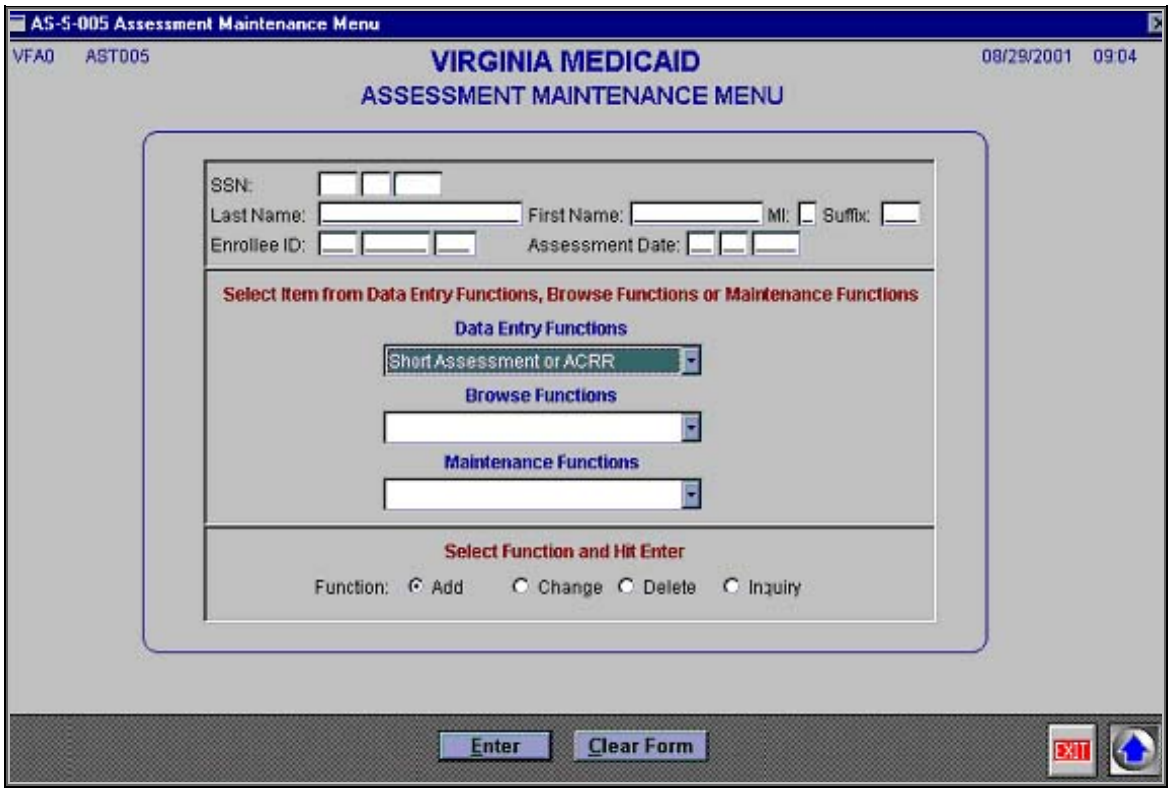
- Short Assessment or ACRR Page 1 Inquiry/Update (AS-S-015)
- Short Assessment or ACRR Page 2 Inquiry/Update (AS-S-020)

Note that these forms are keyed even if some data fields are missing or obviously incorrect. The system will pend incomplete records and generate a Turnaround Document (TAD) cover letter to the provider requesting correction of data that is in error.

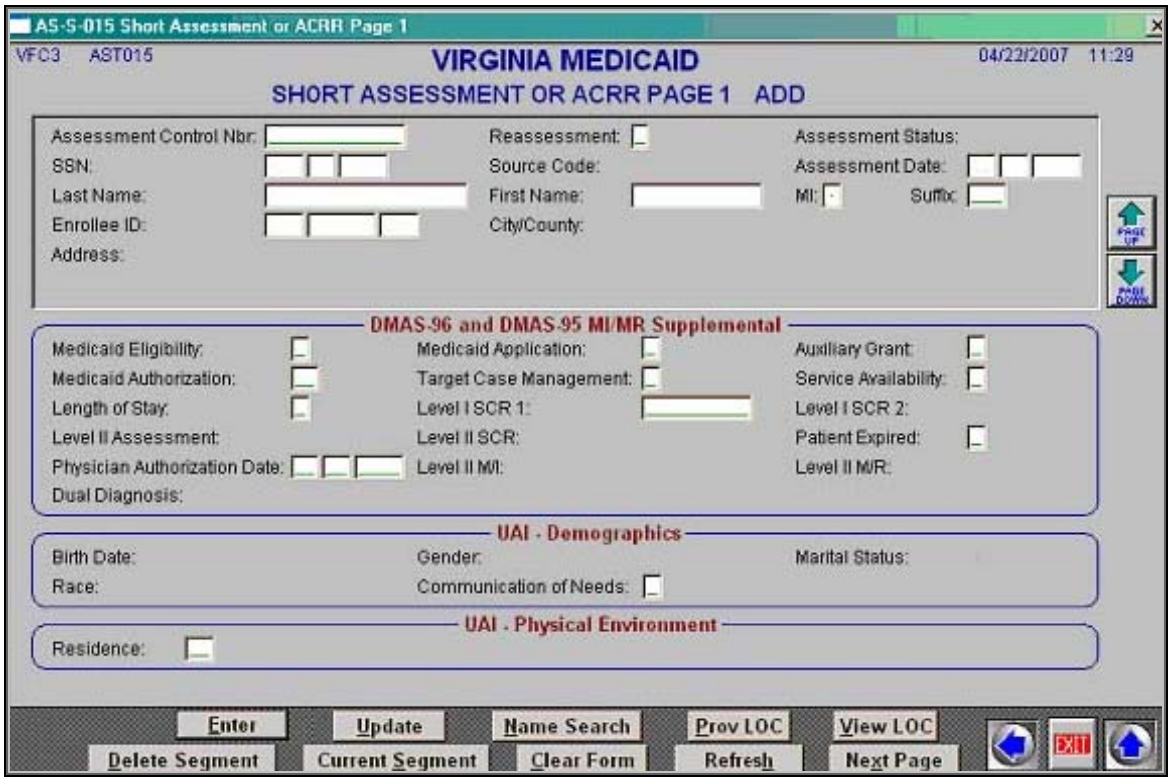
Procedure

1. Click on the **Assessments** icon on the **Main System Menu**
2. On the **Assessment Maintenance Menu**, enter the SSN or enrollee ID from the assessment form.
3. Select *Short Assessment* or *ACRR* from the **Data Entry Functions** drop down box.
4. Click Add, then choose **Enter**.

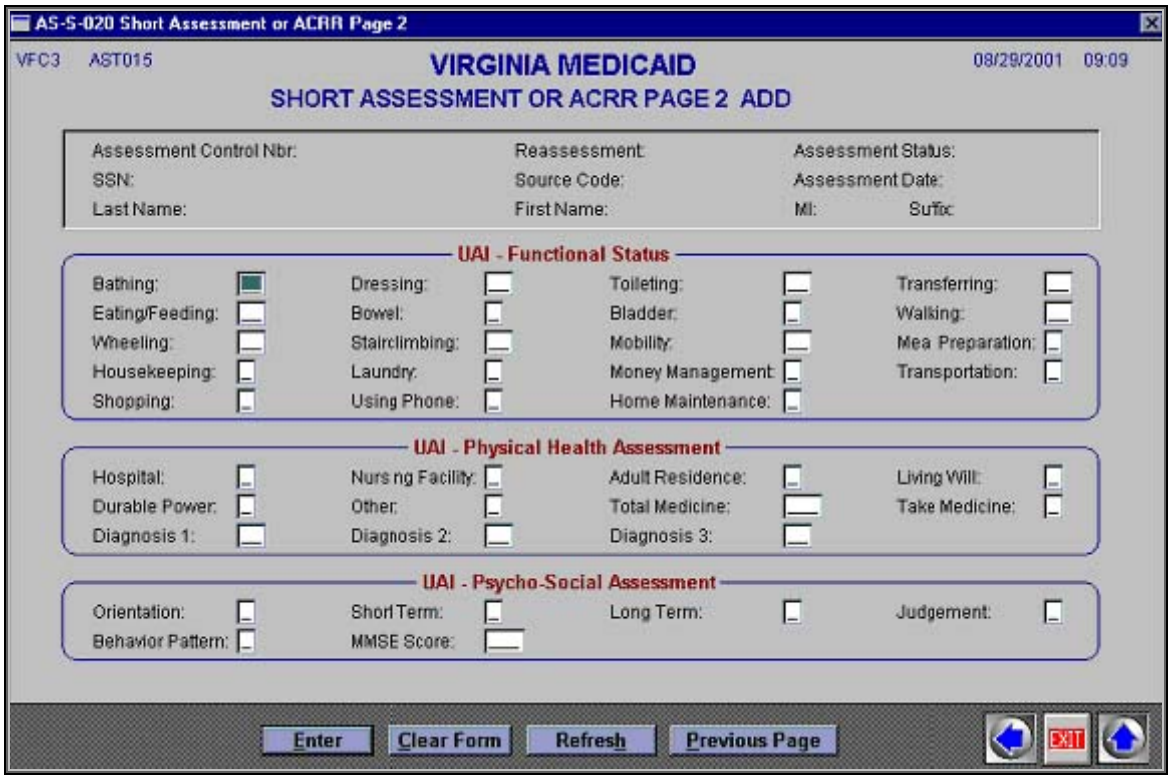
5. Follow instruction in the Financial User Manual to enter the assessment form.
6. When entering the screener information, if the screener Identifier is an NPI and the provider has more than one servicing location, when the **Enter** key is pressed, the system will display the **Provider Location** screen (PS-S-018) and require the user to select a location. Select the first servicing location listed on the screen by entering an *S* in the **Select** field beside that location. Press the **Return** navigation button to return to the **Assessment** screen and continue entering data.



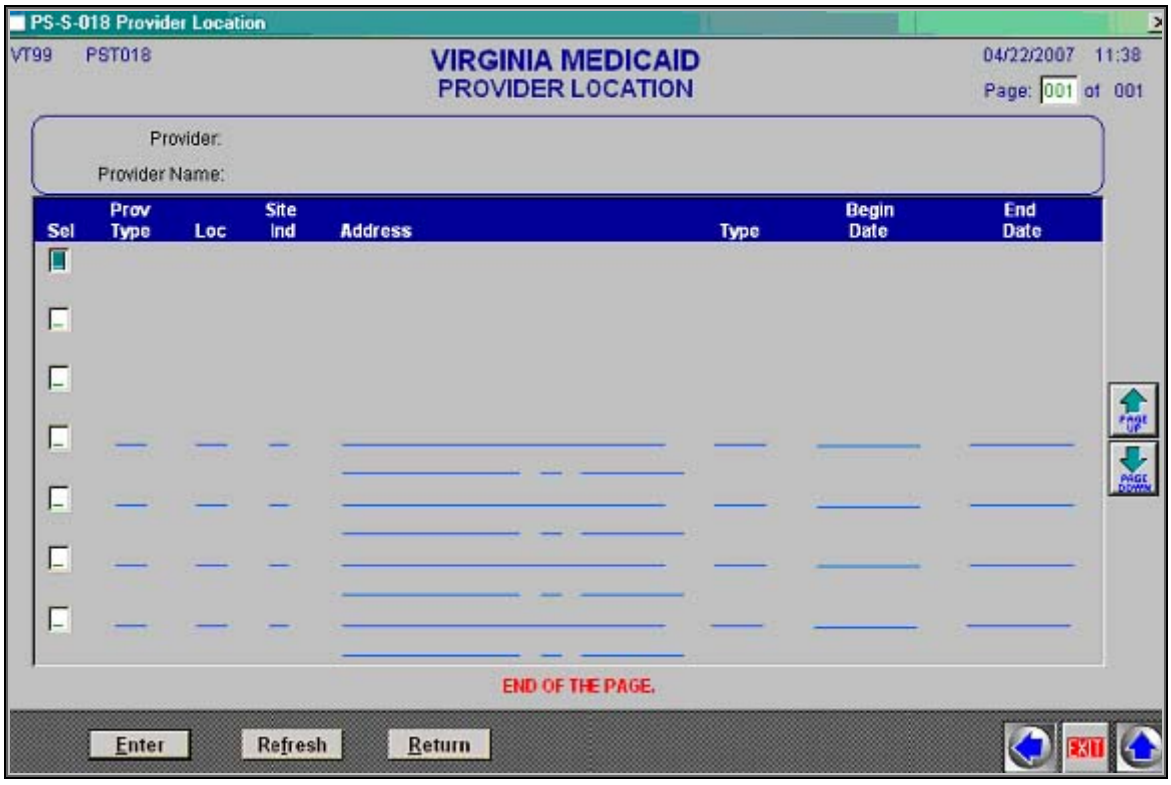
Sample Assessment Maintenance Menu



Sample Short Assessment or ACRR Add Screen Page 1 - Screen # AS-S-015



Sample Short Assessment or ACRR Add Screen Page 2 – Screen # AS-S-020



Sample Provider Location Screen

3.6 DMAS-96 and Uniform Assessment Instrument (UAI) – Full Assessment

This packet includes the DMAS 96 form and the UAI form. The packet is keyed using the following MMIS on-line screens:

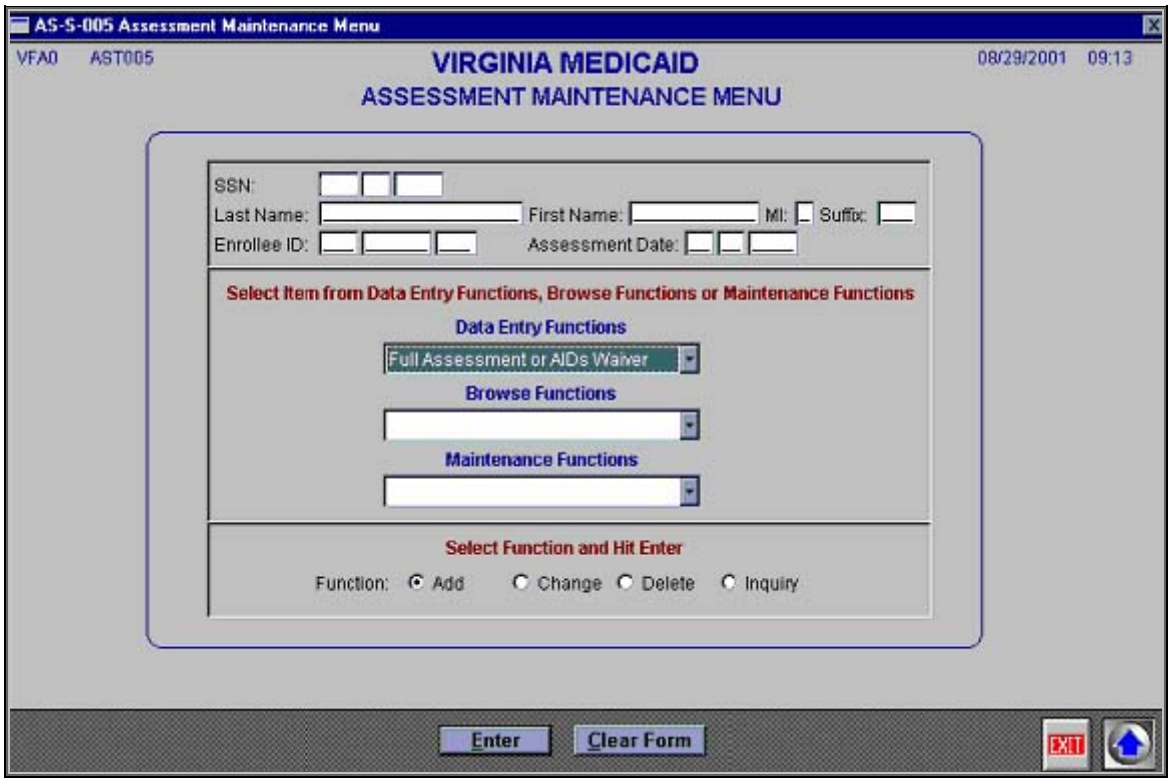
- Full Assessment – Page 1 Inquiry/Update (AS-S-025)
- Full Assessment – Page 2 Inquiry/Update (AS-S-030)
- Full Assessment – Page 3 Inquiry/Update (AS-S-035)

Note that these forms are keyed even if some data fields are missing or obviously incorrect. The system will pend incomplete records and generate a Turnaround Document (TAD) cover letter to the provider requesting correction of data that is in error.

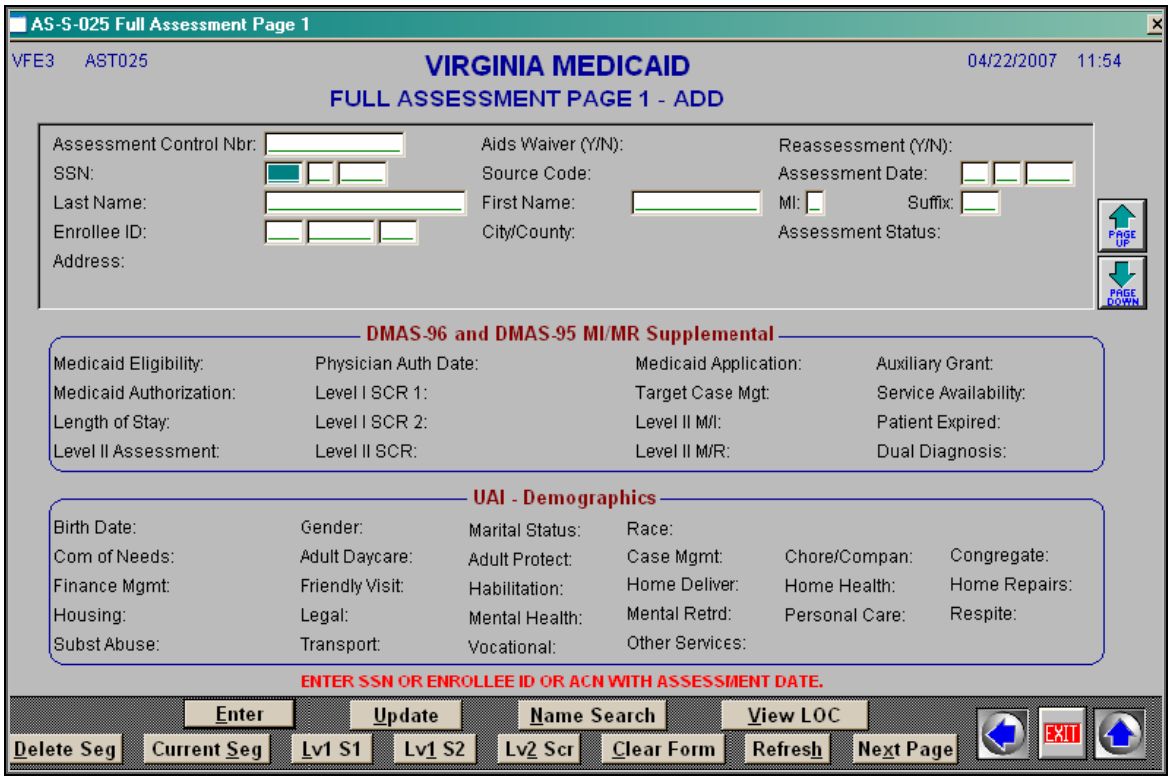
Procedure

1. Click on the **Assessments** icon on the **Main System Menu**.
2. On the **Assessment Maintenance Menu**, enter the SSN or enrollee ID from the assessment form.
3. Select *Full Assessment* from the **Data Entry Functions** drop down box.

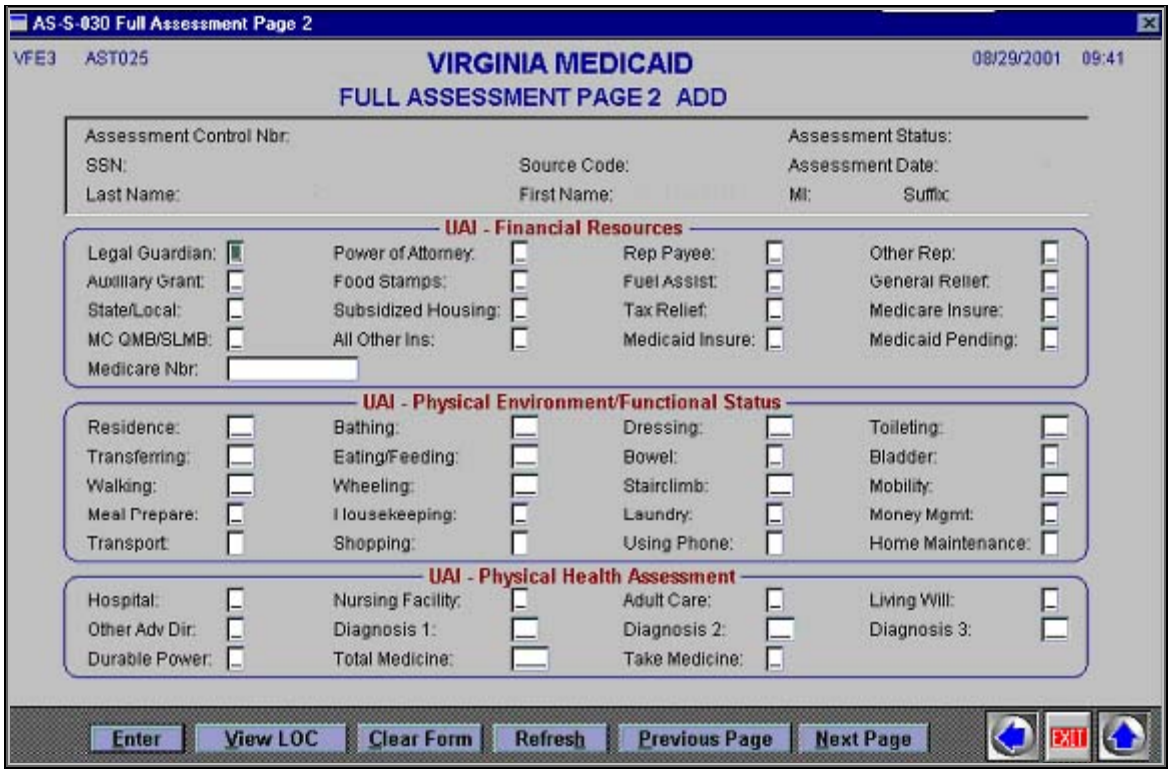
4. Click **Add**, then choose **Enter**.
5. Follow instruction in the Financial User Manual to enter the assessment form.
6. When entering the screener information, if the screener Identifier for any of the screeners is an NPI and the provider has more than one servicing location, when the **Enter** key is pressed, the system will display the **Provider Location** screen (PS-S-018) and require the user to select a location. Select the first servicing location listed on the screen by entering an *S* in the **Select** field beside that location. Press the **Return** navigation button to return to the **Assessment** screen and continue entering data.



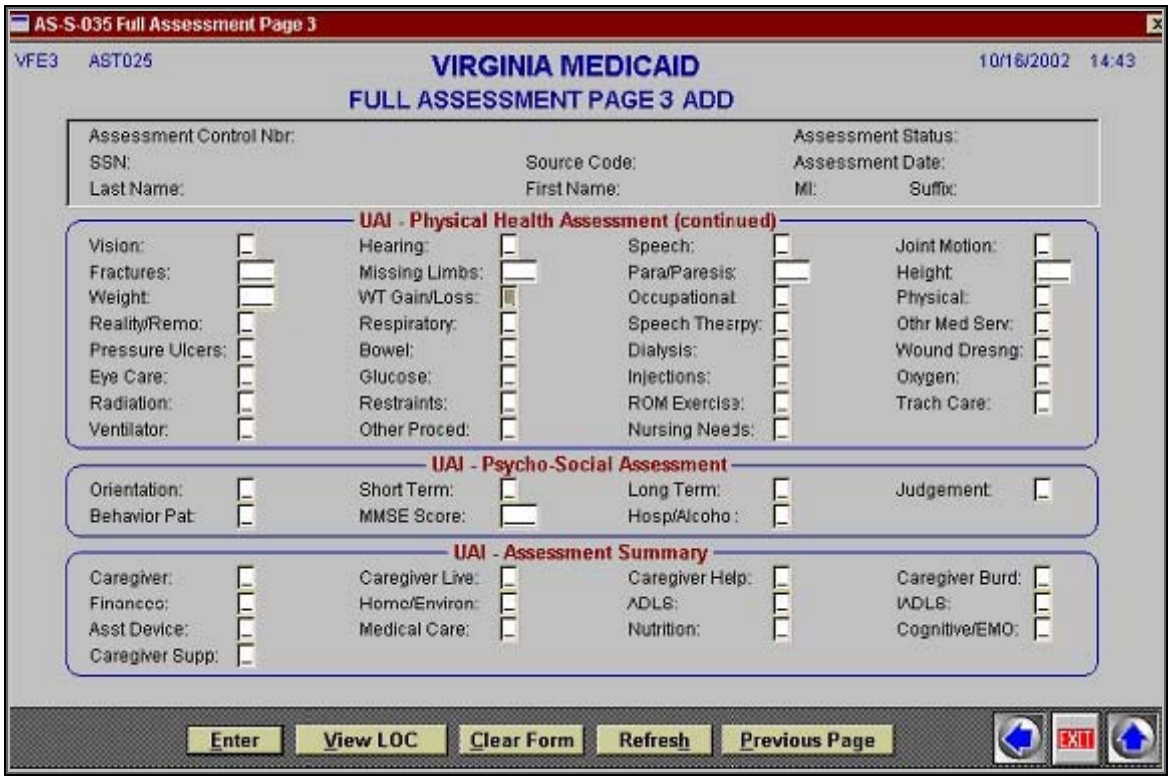
Sample Assessment Maintenance Menu



Sample Full Assessment Page 1 Add – Screen # AS-S-025



Sample Full Assessment Page 2 Add – Screen # AS-S-030



Sample full Assessment Page 3 Add – Screen # AS-S-035

3.7 Medicaid HIV Waiver Pre-Screening Assessment/Pre-Screening Plan of Care

This packet includes the DMAS 113A and DMAS 113B forms. They are keyed using the following MMIS on-line screen:

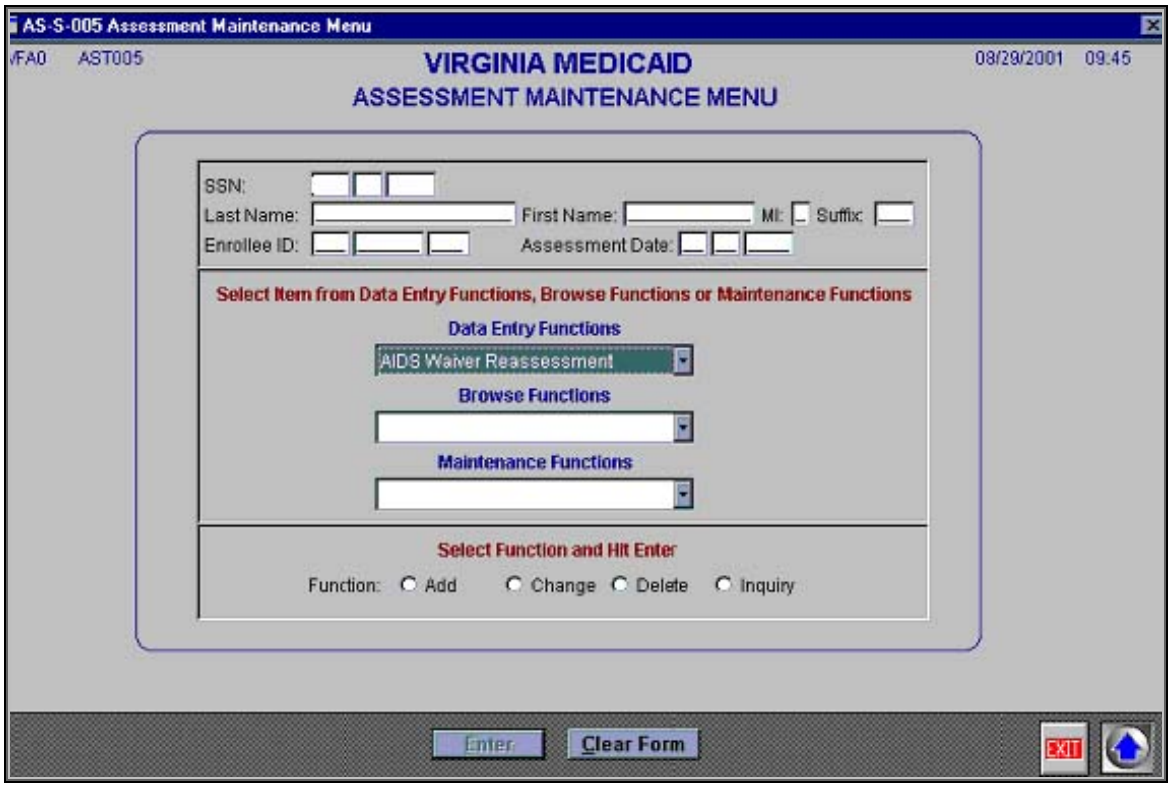
- AIDS Waiver Reassessment Inquiry/Update (AS-S-040)

If the Aids Waiver form is included with a full assessment, this screen is keyed after the three screens for the Full Assessment are completed. If this is a reassessment, this screen is the only one that needs to be keyed.

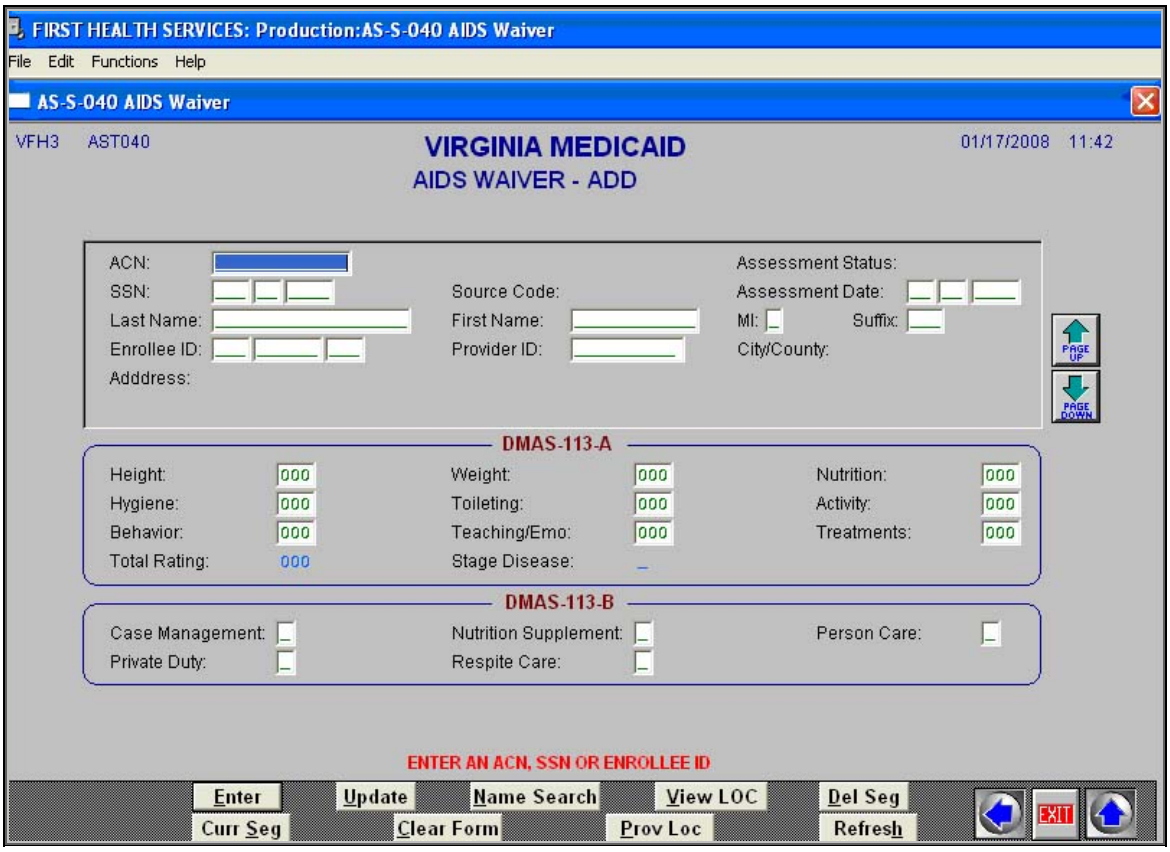
Procedure

1. Click on the **Assessments** icon on the **Main System Menu**
2. On the **Assessment Maintenance Menu**, enter the SSN or enrollee ID from the assessment form.
3. Select *AIDS Waiver Reassessment* from the **Data Entry Functions** drop down box for a reassessment. If the form is attached to an initial full assessment, this screen is accessed from the full assessment upon completion.

4. Enter the ACN (Assessment Control Number) number again. You will have to key an *H* at the end of the ACN to process the assessment.
5. Click **Add**, then choose **Enter**.
6. Follow instructions in the **Financial User Manual** to enter the assessment form.



Sample Assessment Maintenance Menu



Sample AIDS Waiver Add – Screen # AS-S-040

3.8 Maternity Risk Screen/Maternal and Infant Care Coordination Record

This packet includes the DMAS 16 form and the new DMAS 50 form, which combines the previously separate DMAS 50 and 51. This packet is keyed using the following MMIS On-line screens:

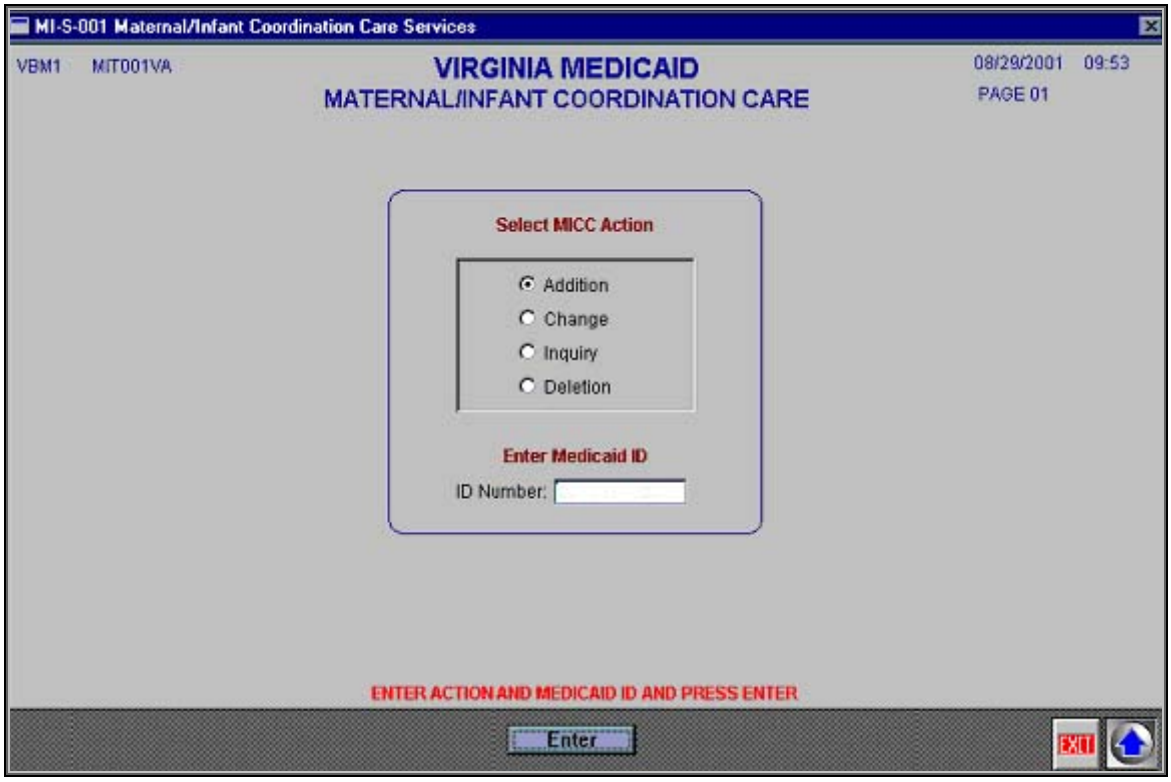
- MICC Maternal Expanded Services – Maternity Risk Screen (MI-S-005)
- MICC Maternal Expanded Services – Maternity MICC Record Screen (MI-S-006)

Procedure

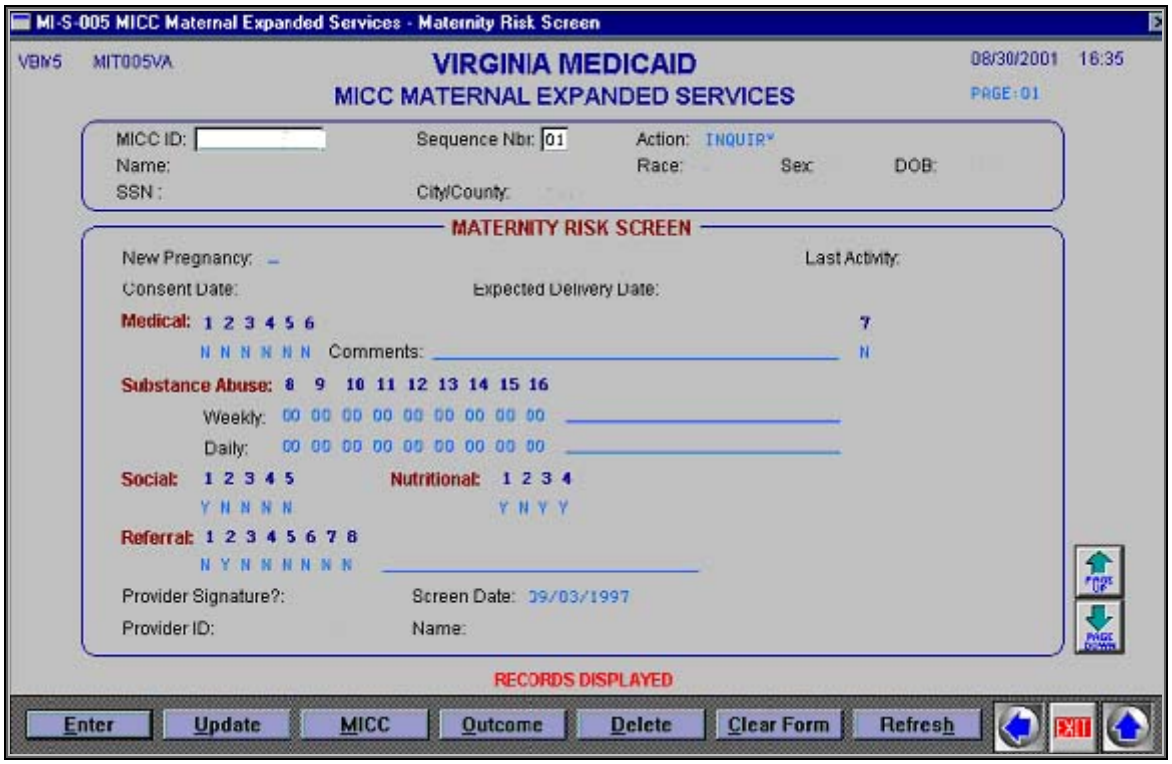
Note: Rejects are to be returned to DMAS for correction. The system does not generate a TAD if there are errors on this form.

1. Click on the **MICC** icon on the **Main System Menu**.
2. On the **MICC Main Menu**, click on the third button, **Maternal/Infant Coordination Care Services**. Choose **Enter**.

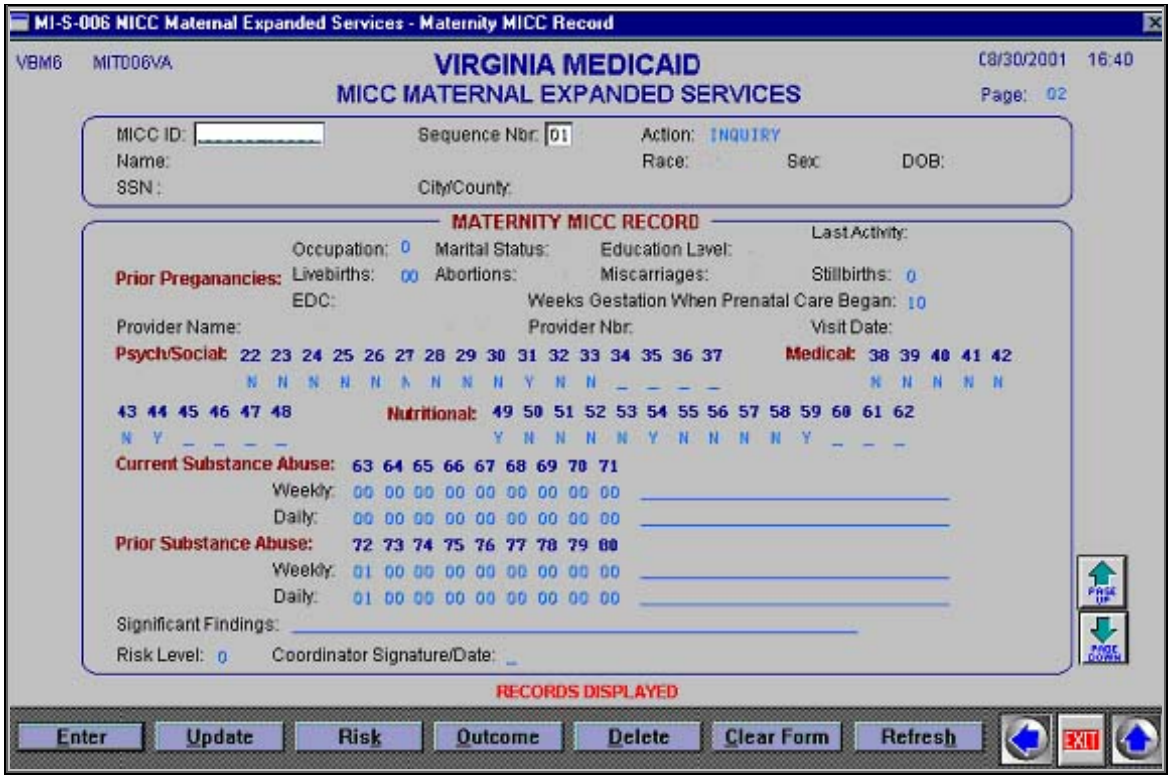
3. On the **Maternal/Infant Coordination Care** screen, click on **Addition**. Enter the ID number from the MICC assessment form. Choose **Enter**.
4. The system will display either the **Maternity** or **Infant Care Coordination** screen depending on the ID number keyed on the Menu.
5. Follow the instructions in the EPSDT User Manual.



Sample Maternal/Infant Coordination Care Screen



Sample MICC Maternal Expanded Services Maternity Risk Screen # MI-S-005



Sample MICC Maternal Expanded Services Maternity MICC Record Screen # MI-S-006

3.9 Infant Risk Screen/Maternal and Infant Care Coordination Record

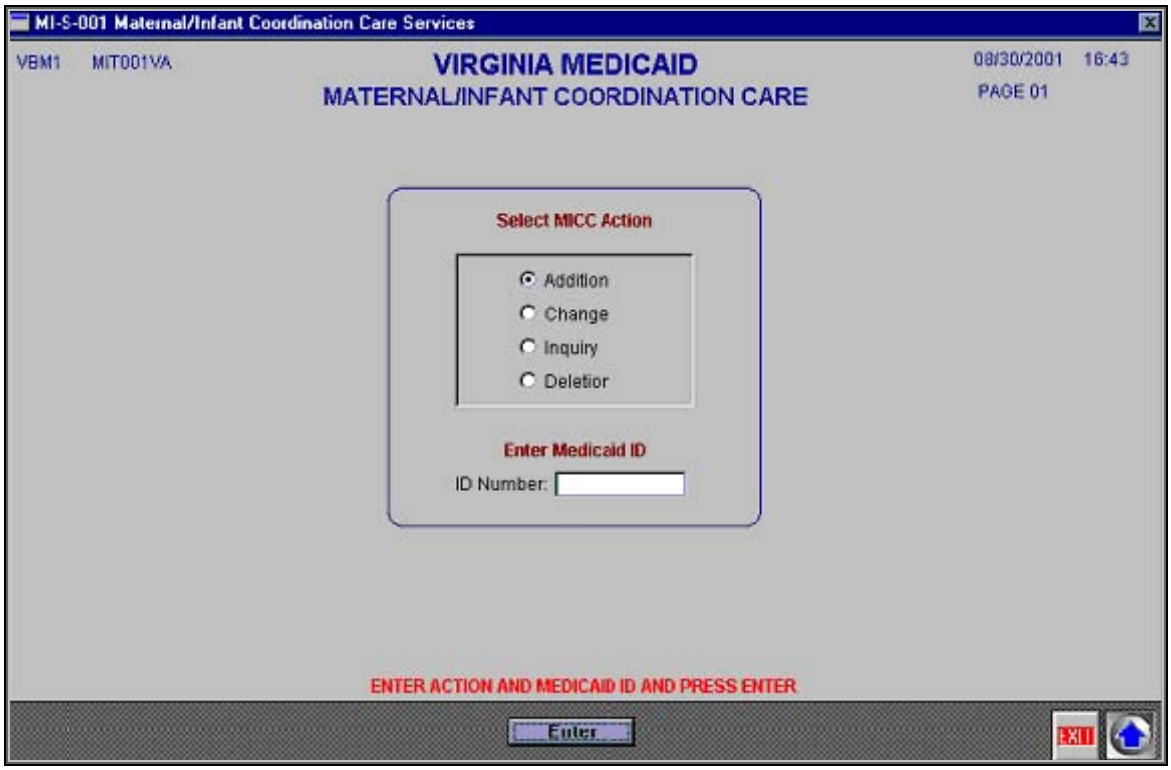
This packet includes the DMAS 17 form and the new DMAS 50 form, which combines the previously separate DMAS 50 and 51. This packet is keyed using the following MMIS On-line screens:

- MICC Infant Expanded Services – Risk Screen (MI-S-002)
- MICC Infant Expanded Services – Infant MICC Report Screen (MI-S-003)

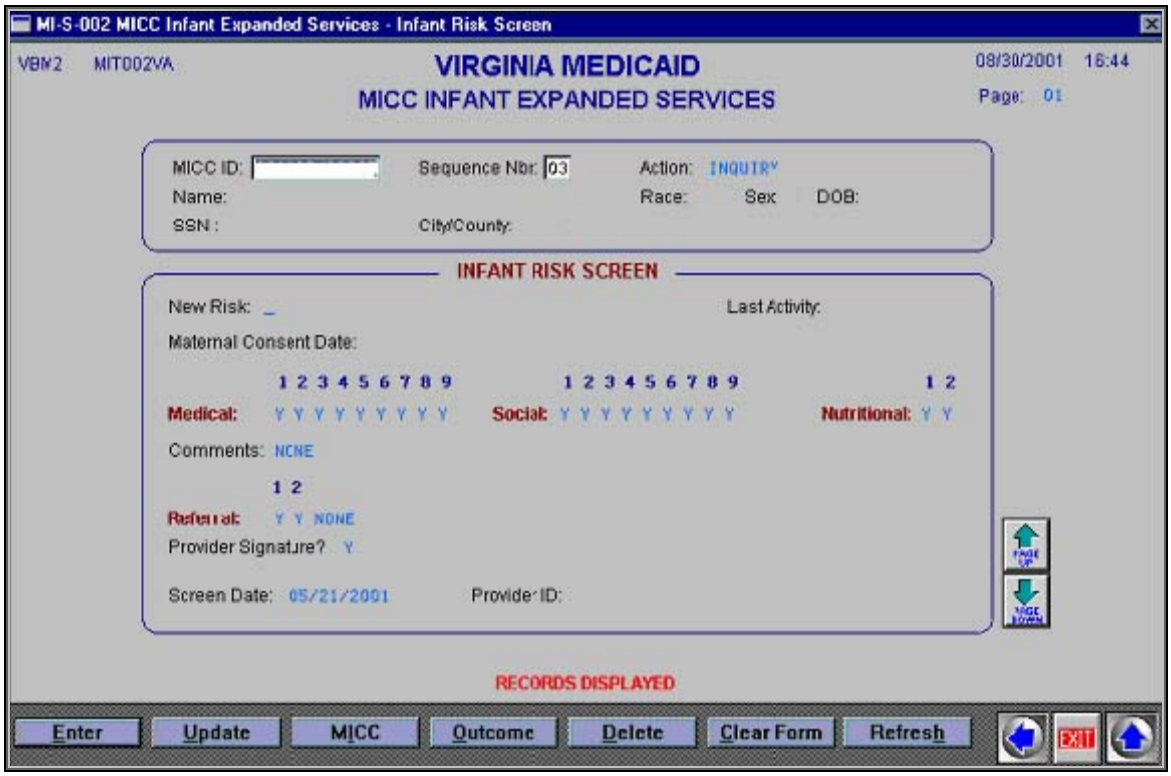
Procedure

Note: Rejects are to be returned to DMAS for correction. The system does not generate a TAD if there are errors on this form.

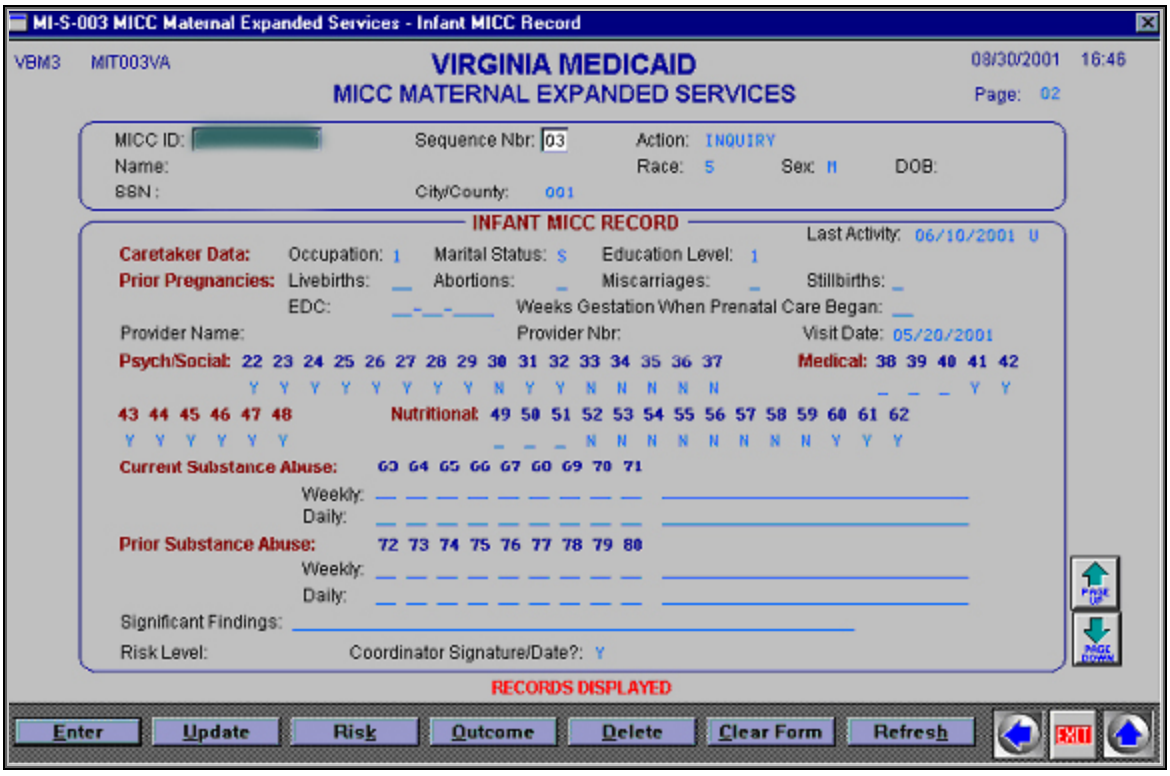
1. Click on the **MICC** icon on the **Main System Menu**.
2. On the **MICC Main Menu**, click on the third button, **Maternal/Infant Coordination Care Services**. Choose **Enter**.
3. On the **Maternal/Infant Coordination Care** screen, click on **Addition**. Enter the ID number from the MICC assessment form. Choose **Enter**.
4. The system will display either the **Maternity** or **Infant Care Coordination** screen depending on the ID number keyed on the menu.
5. Follow the instructions in the EPSDT User Manual.



Sample Maternal/Infant Coordination Care Screen



Sample MICC Infant Expanded Services Infant Risk Screen # MI-S-002



Sample MICC Maternal Expanded Services Infant MICC Record – Screen # MI-S-003

3.10 MICC Infant Outcome Report

This is the DMAS 52 form. This form is keyed using the following MMIS Online screens:

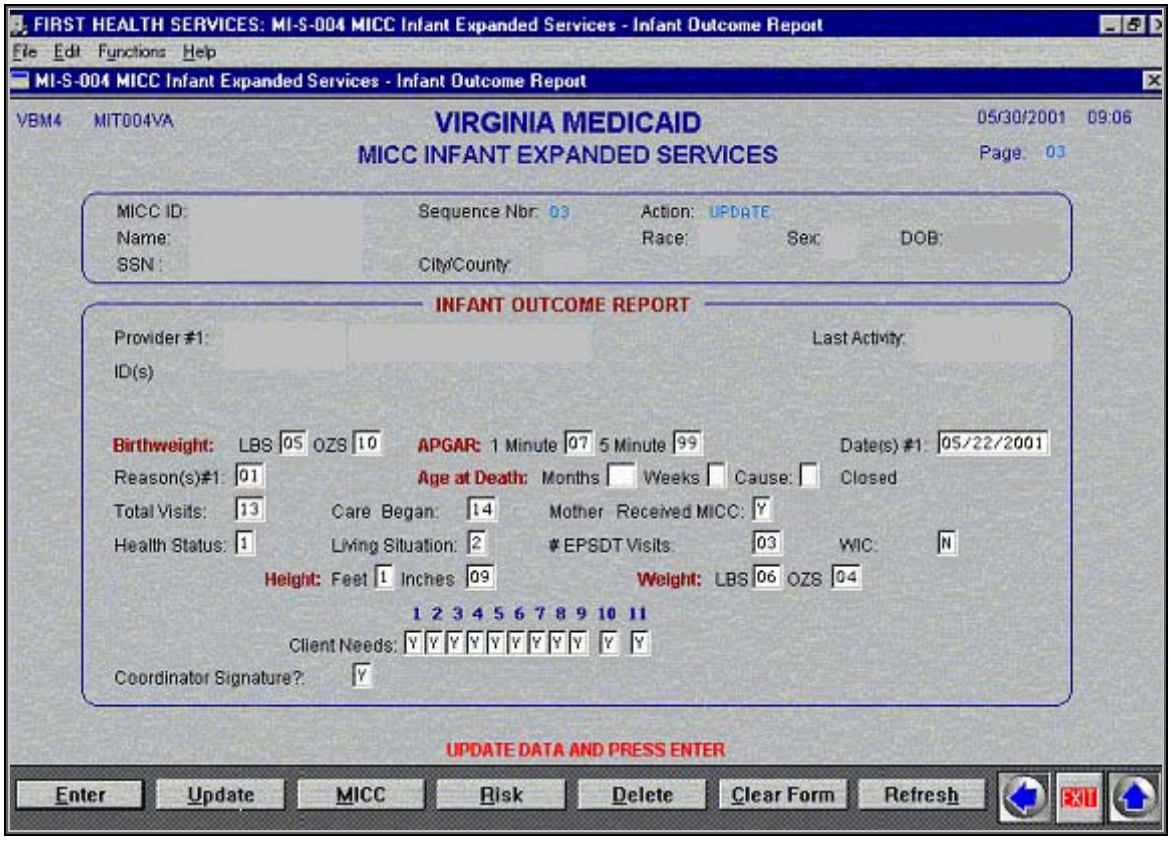
- MICC Infant Expanded Services – Infant Outcome Report Screen (MI-S-004)

Procedure

Note: Rejects are to be returned to DMAS for correction. The system does not generate a TAD if there are errors on this form.

1. Click on the **MICC** icon on the **Main System Menu**.
2. On the M**ICC Main Menu**, click on the **Maternal/Infant Coordination Care Services** radio button. Choose **Enter**.
3. On the **Maternal/Infant Coordination Care** screen, click on **Addition**. Enter the ID number from the MICC assessment form. Choose **Enter**.
4. The system will display the **Infant Care Coordination**.
5. Choose the **Outcome** button.

6. You see the **MICC Infant Expanded Services - Infant Outcome Report** screen (MI-S-004).
7. Follow the instructions in the EPSDT User Manual for entering data from the form.



Sample MICC Infant Expanded Services Infant Outcome Report – Screen # MI-S-004

3.11 MICC Pregnancy Outcome Report

This is the DMAS 53 form. This form is keyed using the following MMIS Online screen:

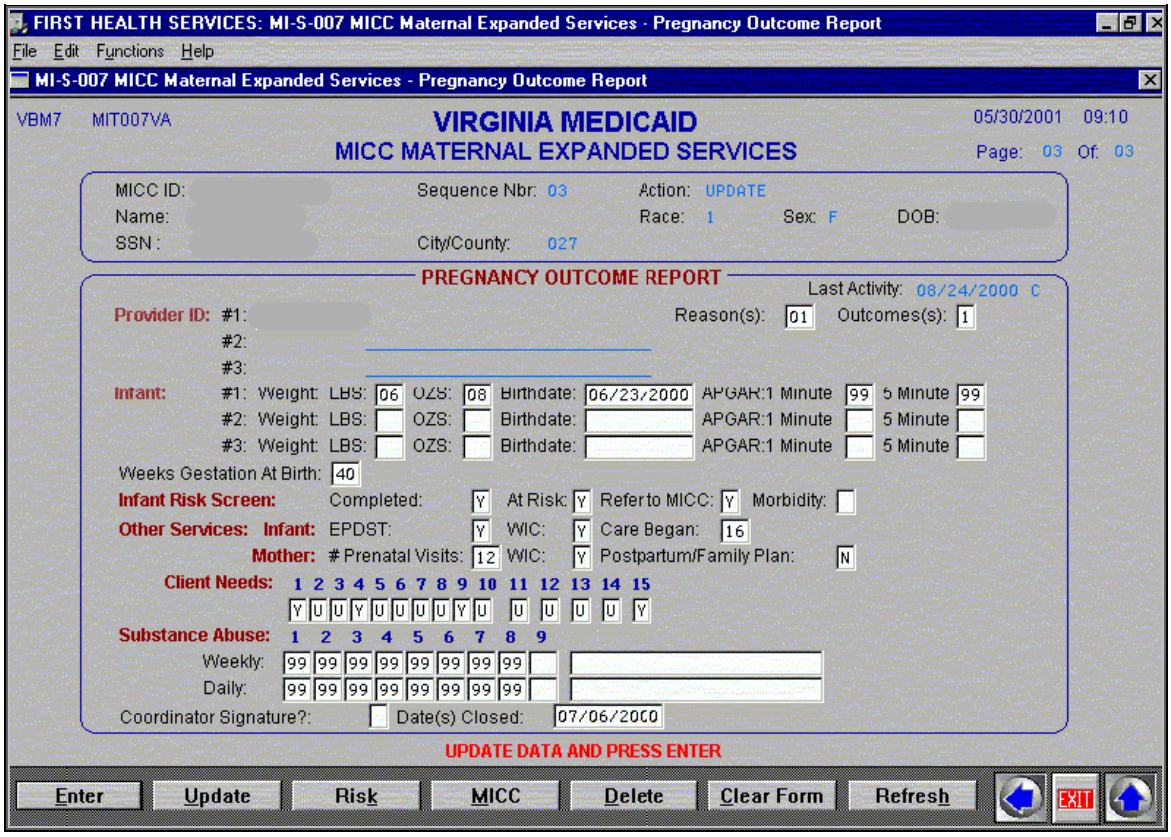
- MICC Maternal Expanded Services – Pregnancy Outcome Report Screen (MI-S-007)

Procedure

Note: Rejects are to be returned to DMAS for correction. The system does not generate a TAD if there are errors on this form.

1. Click on the **MICC** icon on the **Main System Menu**.
2. On the **MICC Main Menu**, click on the **Maternal/Infant Coordination Care Services** radio button. Choose **Enter**.

3. On the **Maternal/Infant Coordination Care** screen, click on **Addition**. Enter the ID number from the MICC Outcome Report form. Choose **Enter**.
4. The system will display the **Maternity Coordination** screen.
5. Choose the **Outcome** button.
6. You see the **MICC Maternal Expanded Services - Pregnancy Outcome Report** screen (MI-S-007).
7. Follow the instructions in the EPSDT User Manual for entering data from the form.



Sample MICC Maternal Expanded Services Pregnancy Outcome Report Screen #MI-S007

3.12 Verifying Keyed Documents

Assessment documents are verified as they are keyed through use of on-line edits and sight verification. On-line edits are presented when the Enter key is clicked after entry of all or part of the data on a given screen. The edit message explains the error and the cursor stops on the field that is in error. You must correct the error if it is caused by mis-keying the data on the Assessment document. If the information on the document was keyed correctly, you may accept the screen with errors. This will cause a TAD to be generated to return the form to the provider

for correction. Before accepting a record, even when there are no on-line edit errors, always sight-verify the data keyed against the data on the form to ensure accuracy.

Procedure

1. When you have keyed all the fields on a single screen, click **Enter** to edit the information.
2. If the system identifies a field that is missing or has invalid data, check the data on the source document. If the data was keyed incorrectly, type over the field with the correct data. Click **Enter** to edit the entry again.
3. Once all errors have been corrected, the system will present a message stating that no errors are found. Sight-verify all fields by checking your entry against the source document.
4. When you have completed the sight verification and all edits have been corrected, click the **Update** button to accept the record.
5. If you have keyed the data as shown on the source document and there are still errors identified by the system, click **Update** to accept the record with errors. Place the source document face down in the TAD holding stack.

3.13 Routing Completed Hard-copy Documents

When operators have completed keying the Assessment Packets, the hardcopy documents are collected and routed to storage or disposal as appropriate:

- Any document that resulted in generation of a TAD is routed to a staging area where it will be matched with the TAD cover letter the following day and sent to the provider.
- Maternal/infant care documents that have errors are returned to DMAS.
- Other completed documents are routed to Data Prep for disposal.

Procedure

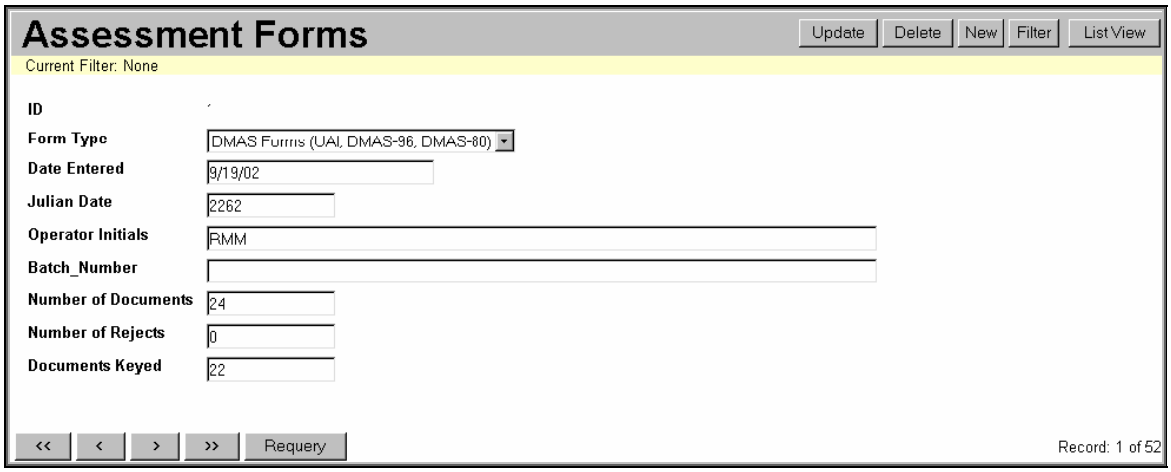
1. After assessments have been entered into the system, place the approved documents in a stack.
2. Route the approved assessments to Data Preparations to be QC’d and destroyed.
3. Refer to Section 4.2.1 for handling of documents that are to be returned with TADs.
4. Collect and route to DMAS any Maternal/Infant Care documents that had errors.

3.14 Log In Daily Assessment Form Totals

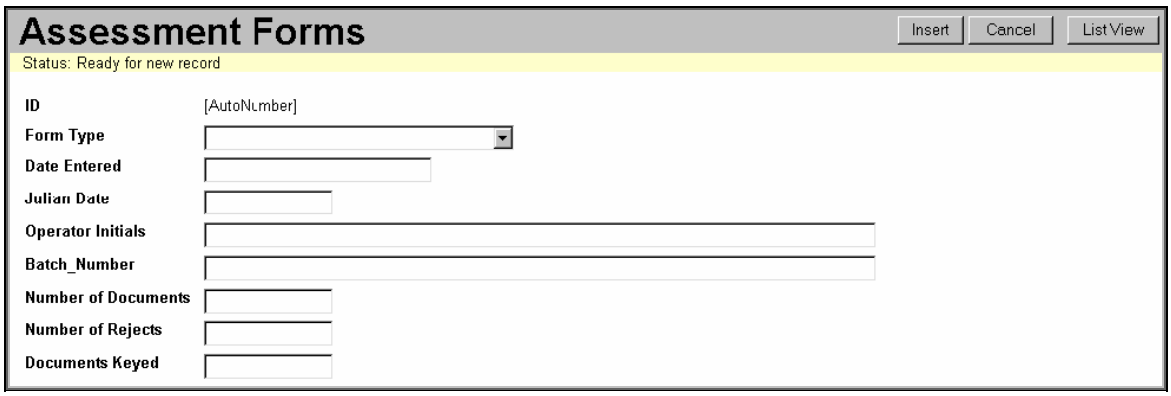
At the end of the processing day, the Assessment Input Supervisor will input a count of each type of assessment processed during the day. These totals will be sent to the Contract Monitoring System (CMS) and will appear as a daily input of assessments processed in Contract Monitoring System reports. Daily totals will be used to accumulate weekly, monthly and yearly totals for DMAS CMS reports

Procedure

1. Count the total number of assessments, both approved and rejected for each assessment type category: DMAS forms, UAI, and Baby Care.
2. Open the **CMS Assessment Daily Maintenance** program.
3. You see this main window. Click on the **New** button.



4. You see the new **Assessment Forms totals entry** window.



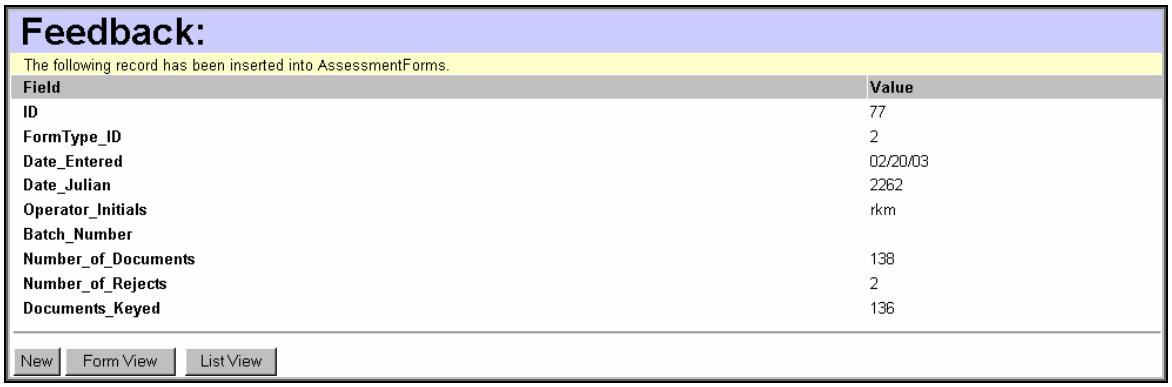
5. Choose an Assessment form type from the **Form Type** drop-menu. Choose from: *DMAS Forms (UAI, DMAS-96, DMAS-80) UAI with AIDS Waiver Baby Care*

6. Enter the date in the **Date Entered** field. Use MM/DD/YY format. The Julian date will automatically calculate.

   Note: You can also enter the Julian date and the day date will automatically populate.

7. Enter your 3-character operator initials in the **Operator Initials** field.
8. Enter the total number of documents received in the **Number of Documents** field. Be sure you enter the total number, not the number of batches.
9. Enter the number of rejected documents in the **Number of Rejects** field.
10. Enter the total number of assessments keyed in the **Documents Keyed** field.
11. When you have finished, click on the **Insert** button at the top of the window.

12. You see a confirmation of your record entry in the **Feedback** window.



13. You can close the window or choose the **List View** button to see all the records entered.

4.0 Process Assessment TADs

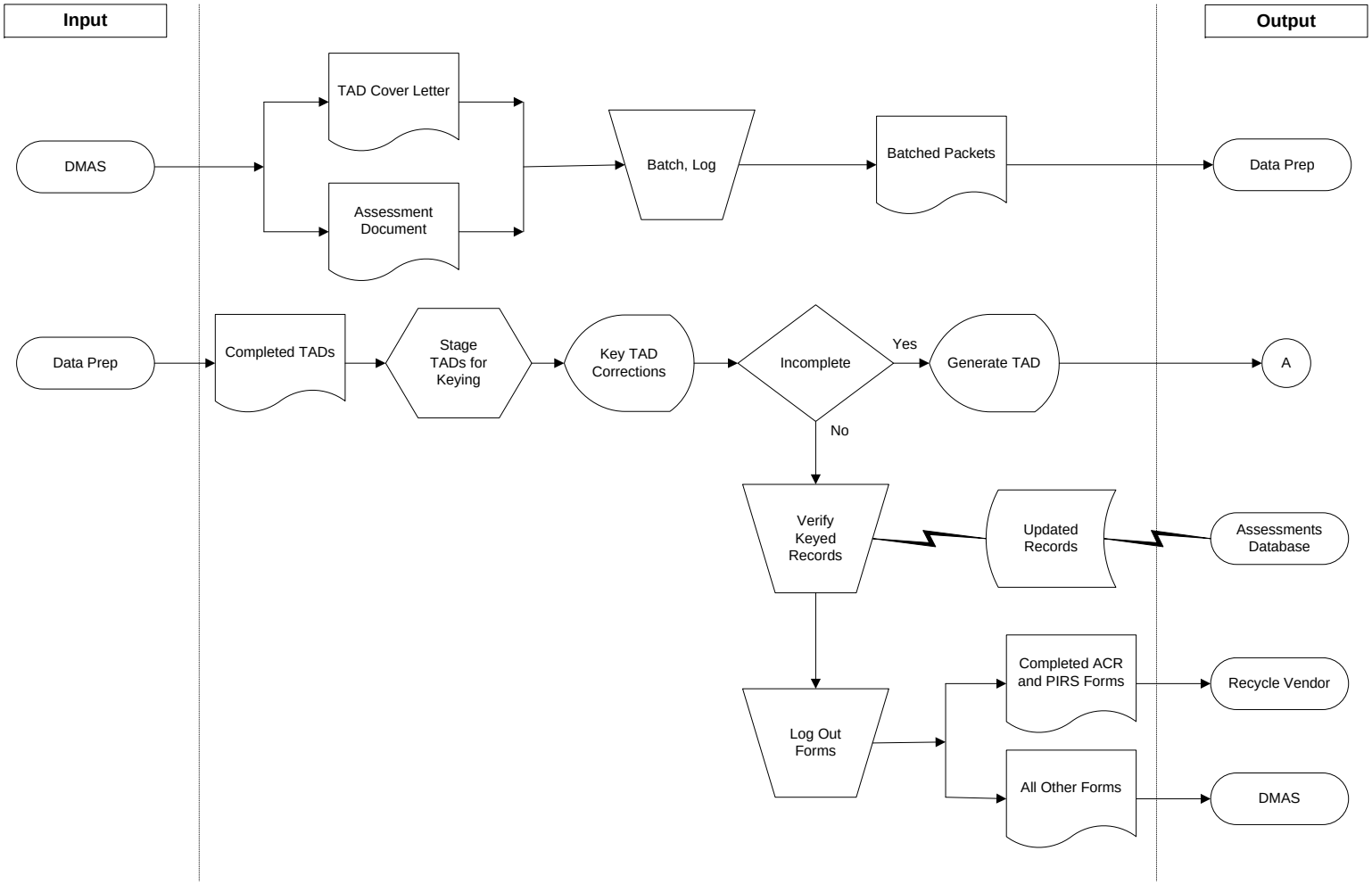
When a Community Based Care (CBC) Assessment is keyed, the system edits the data entered for completeness and validity. If the document is not approved because certain data is missing or invalid, or is a possible duplicate, the system will suspend the Assessment and automatically generate a TAD Cover Letter asking the provider to correct the fields in error. The operator will see a message that indicates the Assessment is being pended and that a TAD cover letter is being generated. The Assessment Packet is then routed for staging to be sent to the provider, or to DMAS if it is a possible duplicate, with the TAD cover letter that will print the following day. When the provider returns the corrected Assessment, the operator will access the pended record on-line and will enter only those fields that have been corrected by the provider. This process applies only to CBC Assessments. Maternal and Infant forms will not be pended by the system. These forms will be returned to DMAS if information is missing or invalid.

DMAS will discontinue submitting comments that are referred to as DMAS TAD forms through inter-office mail. These forms were used for PIRS only.

A sample TAD cover letter is included in Appendix B: TADs.

WORKFLOW PROCESS

File Maintenance Procedures: Process Assessment TADs



4.1 Process Outgoing TADs

The system will automatically generate a TAD cover letter for a CBC Assessment that cannot be approved because of missing or invalid data. The cover letter will print the following day and is to be matched to the hardcopy document packet submitted by the provider. This process does not apply to the Maternal and Infant forms. These forms will be returned to DMAS for correction of errors.

Procedure

1. Collect documents that were rejected the day before.
2. Match Assessment documents with TAD Cover Letters delivered to Data Entry from QC.
3. Count how many TADS are being sent out and put count on Control Log for Assessment TADs. A sample log is included in Appendix C: TAD Control Log.
4. Fold Assessment document and TAD cover letter and insert into envelope.
5. Send envelopes to mailroom for mailing.

4.2 Receiving/Staging Returned TADs

Once the provider has corrected the Assessment document the forms are returned to the First Health Post Office box. The returned forms will be imaged, then routed to the Assessments unit to be keyed.

Procedure

1. Receive TADS from Data preparations.
2. Distribute to Data Entry operators to key.

4.3 Keying TADs

The returned TAD Assessment documents are keyed into the pending Assessment record. The operator accesses the record using the ACN of the original document and keys the new ACN, then only the corrected data. If there are still errors in the document, the system will generate a second TAD cover letter and the process is repeated.

Procedure

1. Access the appropriate screen for the type of corrected assessment you are keying.
2. Enter the ACN of the original document, or the enrollee's SSN or Enrollee ID and click **Enter** to retrieve the pended record.

3. Type over the original ACN with the new ACN that is on the TAD Cover Letter.
4. Note the fields that are in error indicated on the TAD Cover Letter.
5. Key the corrections from the corrected document.
6. If there are still fields in error, accept the record and allow it to repend.
7. Stage the corrected document to be returned to the provider for another correction.

4.4 Process DMAS LTC Utilization Review of PIRS Results TADs

This is a free-form document sent from DMAS via inter-office mail and is currently referred to as a DMAS TAD. These forms are now discontinued as they apply to PIRS only.

Procedure

Not applicable.

4.5 Routing Completed Hardcopy Documents

When operators have completed keying the Assessment TADs, the hard-copy documents are logged out and routed to storage or disposal as appropriate:

- Any document that resulted in generation of another TAD is routed to a staging area where it will be matched with the TAD cover letter the following day and sent to the provider.
- Other completed TAD documents are routed to the recycle vendor after 10 days.

Procedure

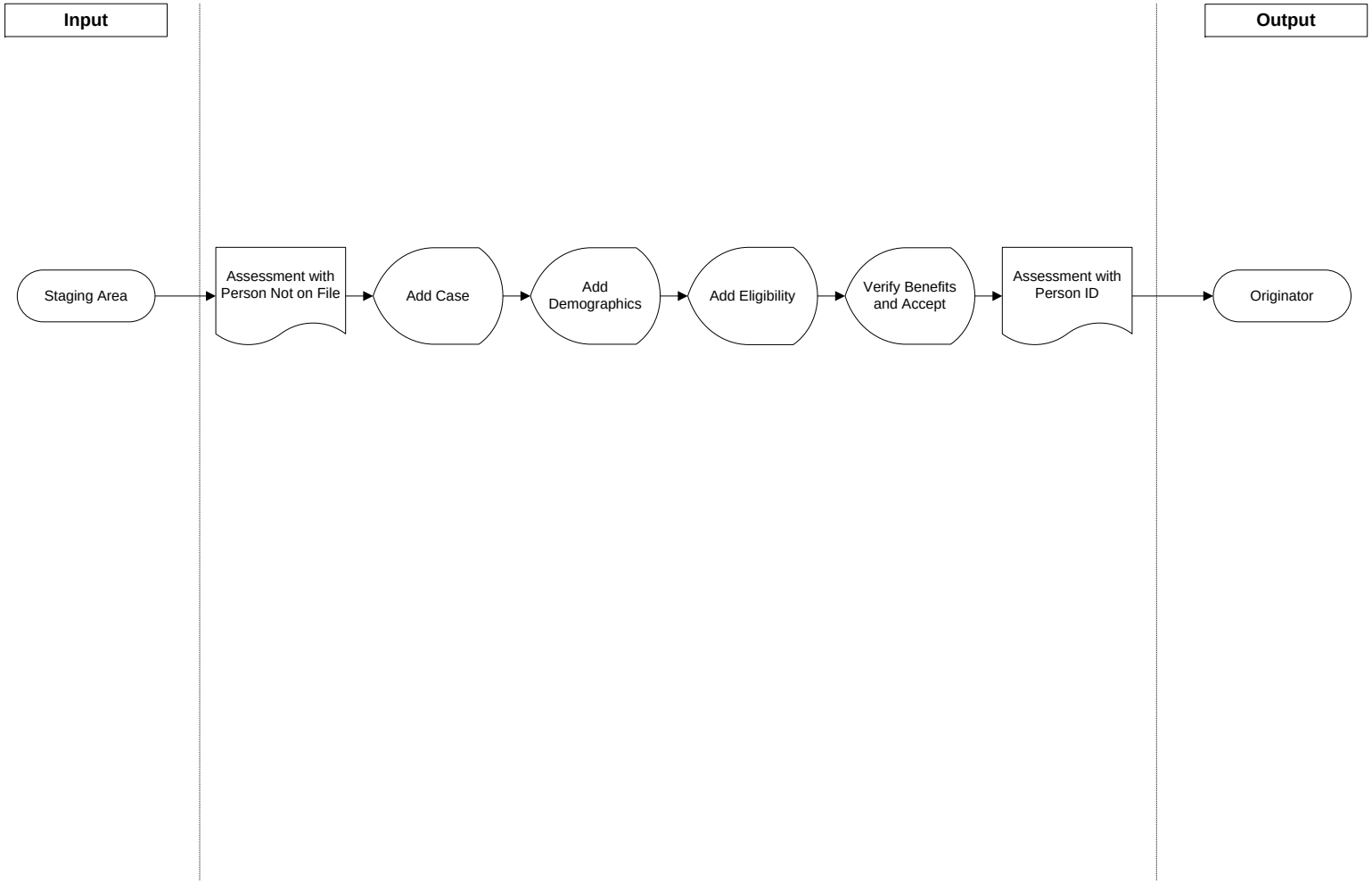
1. After Data Entry operators have keyed the TADs, pick up the ones that generated a new TAD and place them with the other documents that are to be matched with TAD cover letters the next day.
2. Pick up the completed TADs and store for 10 days.
3. At the end of the 10-day storage period, place the documents in the recycle bin.

5.0 Adding Enrollees to File for Screening Assessments

Assessment forms cannot be entered into the MMIS unless the person being screened is on the MMIS Person File and is active on the screening date. For screenings that assess persons for the purpose of determining eligibility, it is likely that the person is not already on file and active. If you are attempting to key an assessment form and the system states the person is not on file or is not active on the date of service, the person must be added to the enrollment file before entering the assessment.

WORKFLOW PROCESS

Add Enrollees for Screening Assessments



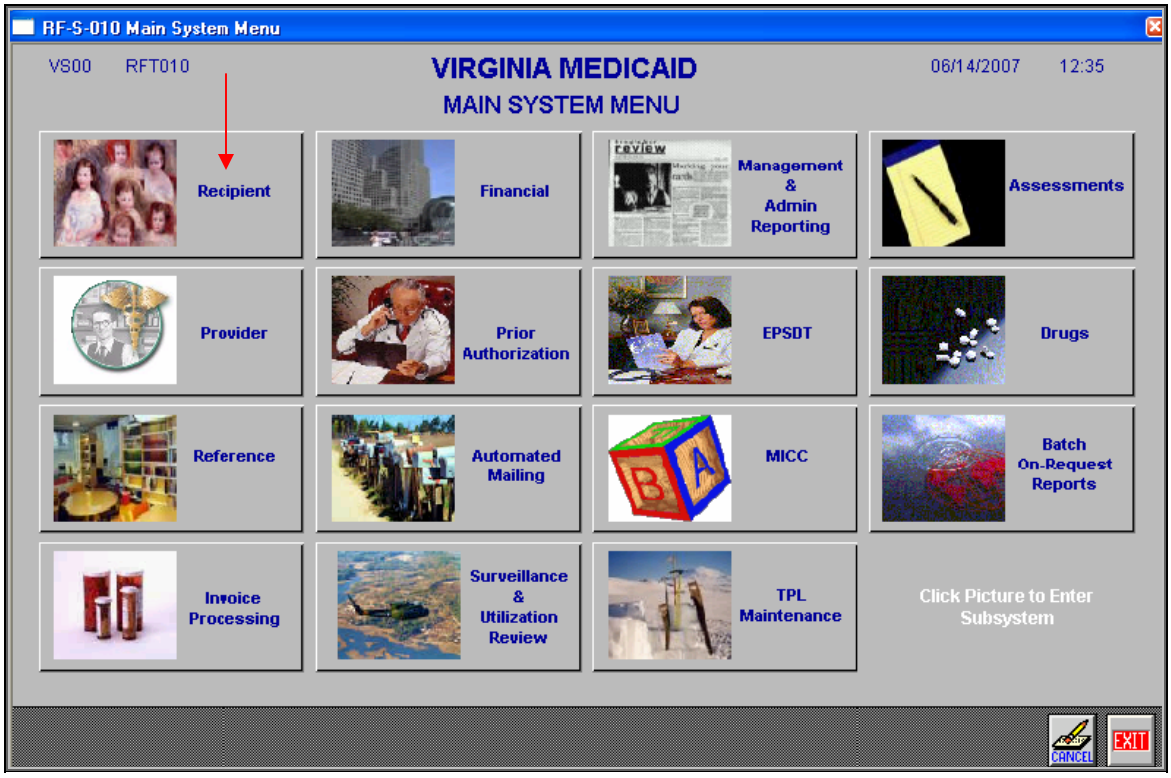
5.1 Adding a Case and Enrollee

To add a person to the Enrollment File, you must use the following MMIS screens:

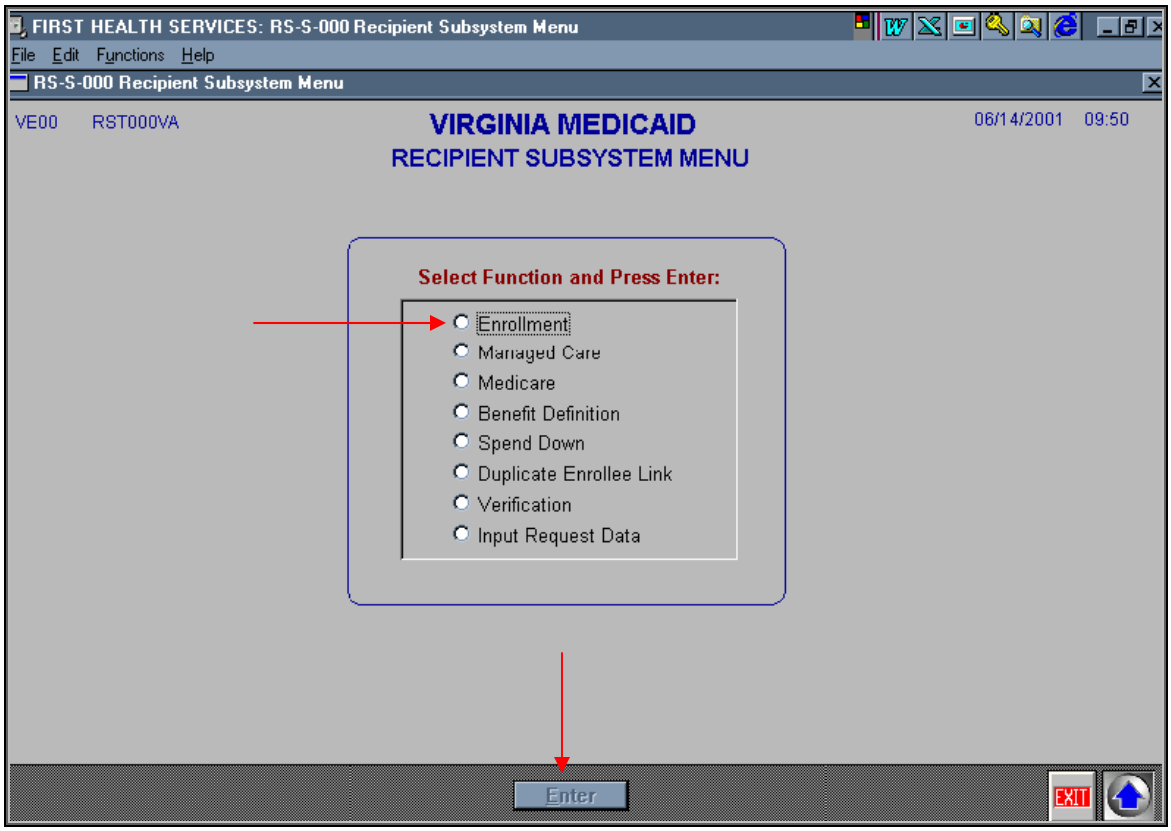
- Recipient Subsystem Menu (RS-S-000)
- Enrollment Menu (RS-S-001)
- Case Data – ADD (RS-S-010)
- Enrollee Demographics – ADD (RS-S-018) Eligibility Data – ADD (RS-S-015)
- Enrollee Benefits – ADD (RS-S-011)

Procedure

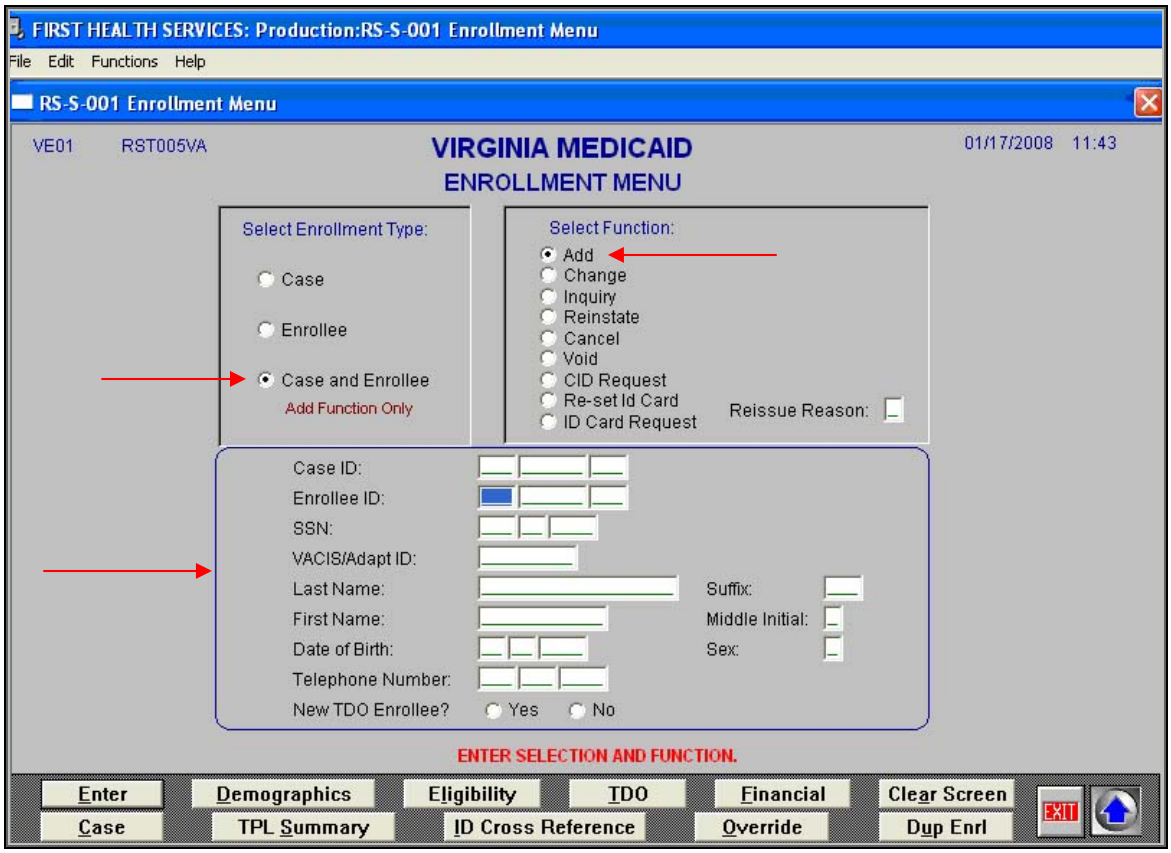
1. Access the **MMIS Main Menu** screen.



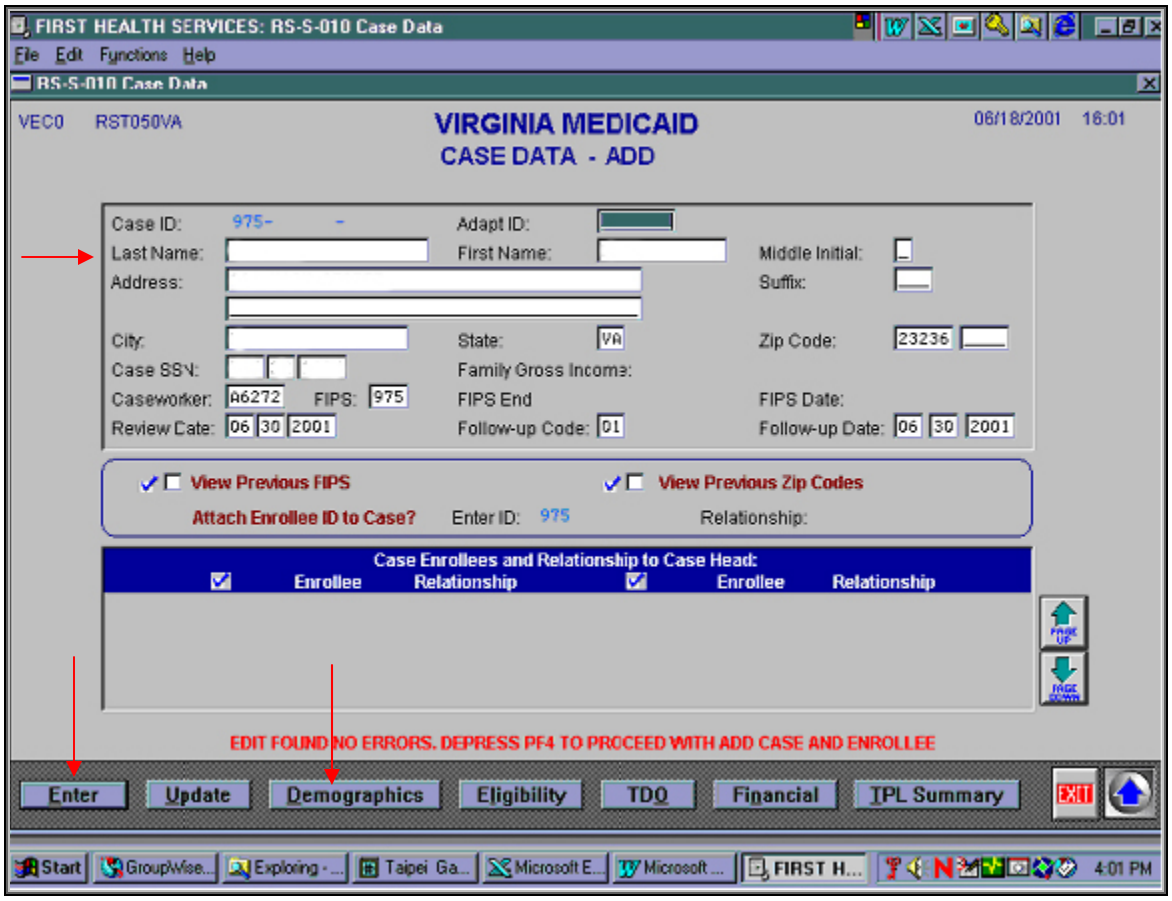
2. Click on the **Recipient** icon.



3. Select Enrollment.
4. Choose **Enter**.



5. Select **Case and Enrollee**.
6. Select **Add**.
7. Enter data as shown in the example:
   - ❖ Case ID – Always enter *975*.
   - ❖ Enrollee ID – Always enter *975*.
   - ❖ SSN – Enter enrollee Social Security number from screening form.
   - ❖ Last Name - Enter enrollee last name from screening form.
   - ❖ First Name – Enter enrollee first name from screening form.
   - ❖ Date of Birth – Enter enrollee date of birth from screening form.
   - ❖ Sex – Enter *F* for female or *M* for male from sex field on screening form.
8. Choose **Enter**.

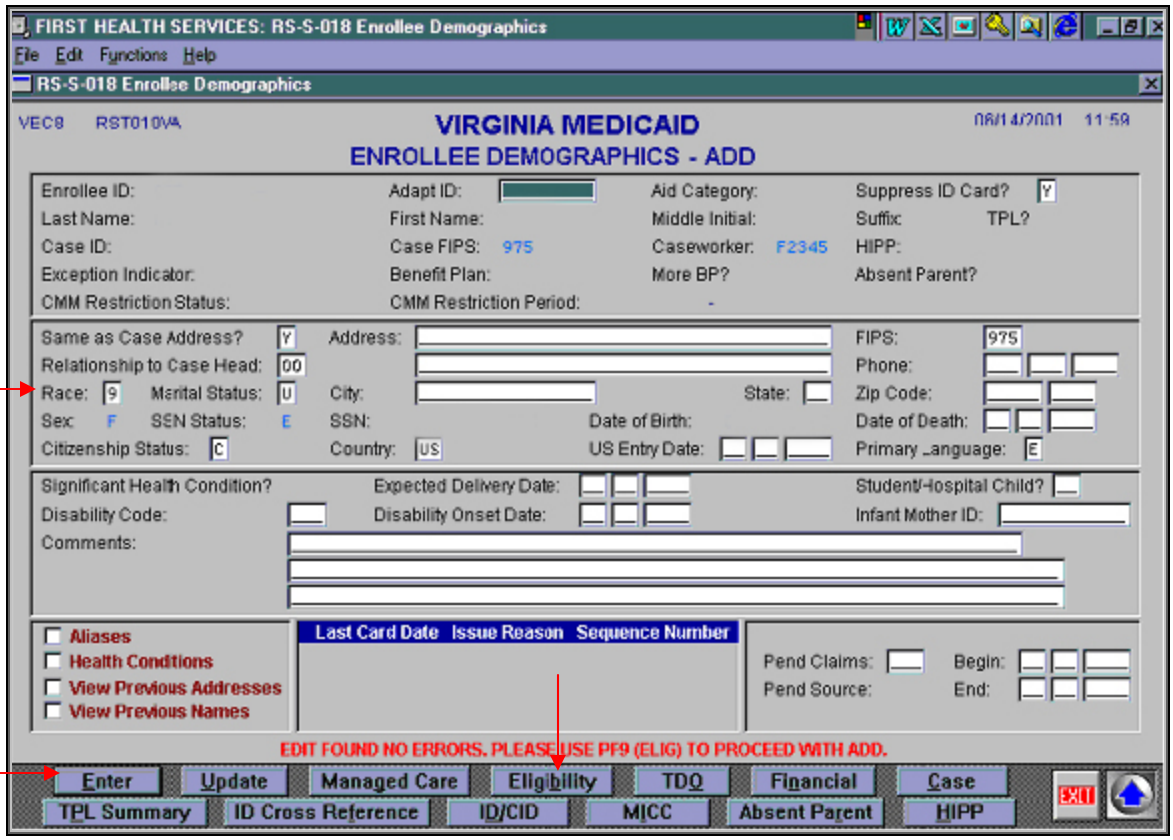


9. Enter Case data as shown in the example:

   - ❖ Last Name – Enrollee last name.
   - ❖ First Name – Enrollee first name.
   - ❖ Address – Enrollee address from screening form.
   - ❖ Case SSN – Enrollee Social Security number.
   - ❖ Caseworker – Caseworker number – Enter your login number (*A9999*).
   - ❖ FIPS – Enter the City/County Code from the screening form.
   - ❖ Review Date – Enter the last day of the current month. For example, if the current date is 6/15/08, enter 6/30/08.
   - ❖ Follow-up Code – Always enter *01*.
   - ❖ Follow-up Date – Enter the same date as the Review Date.

10. Choose **Enter**.

11. If no errors, click **Demographics** to update.

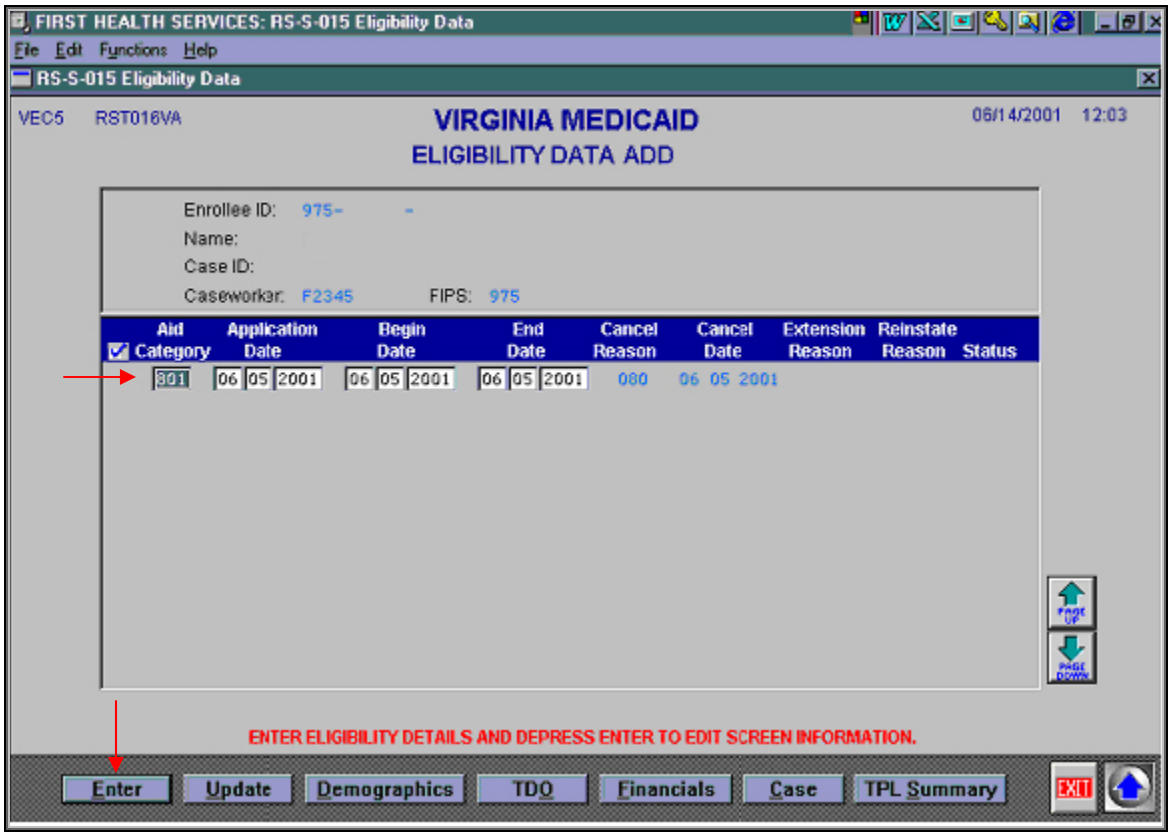


12. Enter data as indicated in the sample above:

- ❖ Suppress ID Card? – Always enter *Y*.
- ❖ Same as Case Address? – Always enter *Y*.
- ❖ Relationship to Case Head – Always enter *00*.
- ❖ Race – Enter the race code from the screening form (*1-6* or *9*).
- ❖ Citizenship Status – Always enter *C*.
- ❖ The rest of the fields are not needed.

13. Click **Enter**.

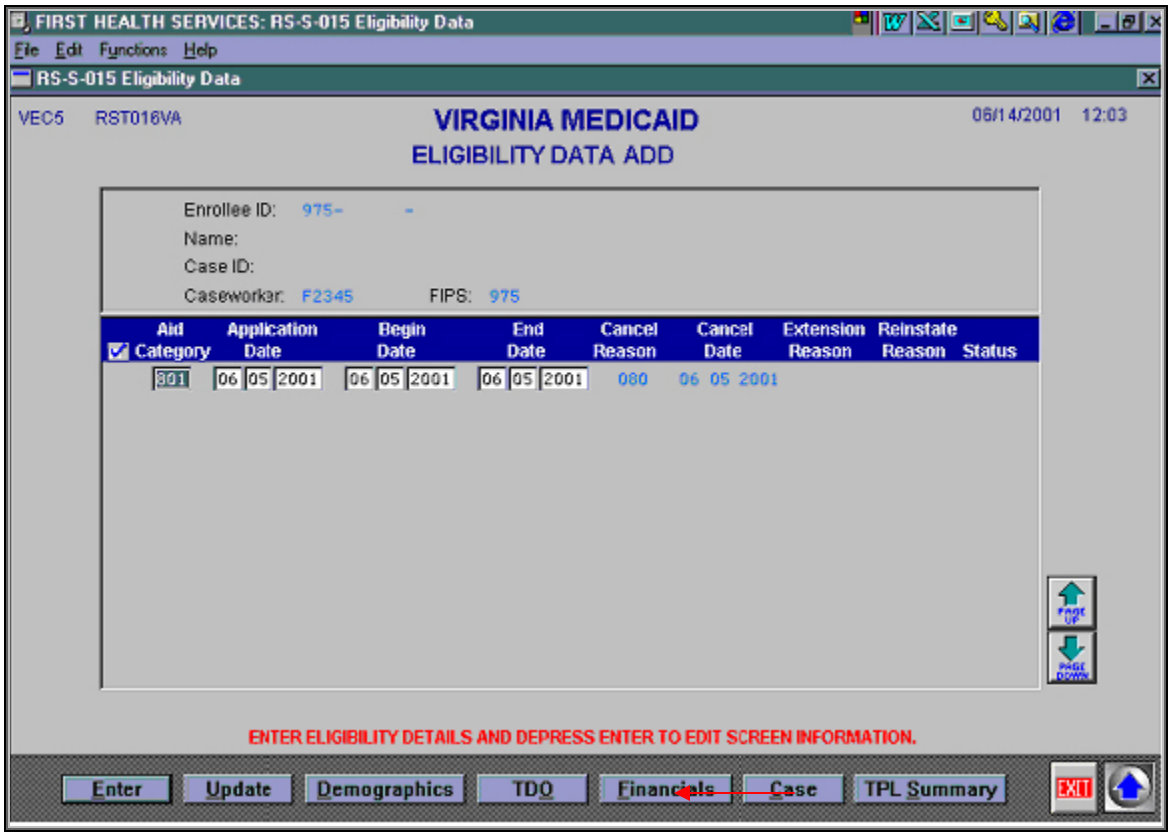
14. If no errors, choose the **Eligibility** button.



15. Enter data as shown on the sample:

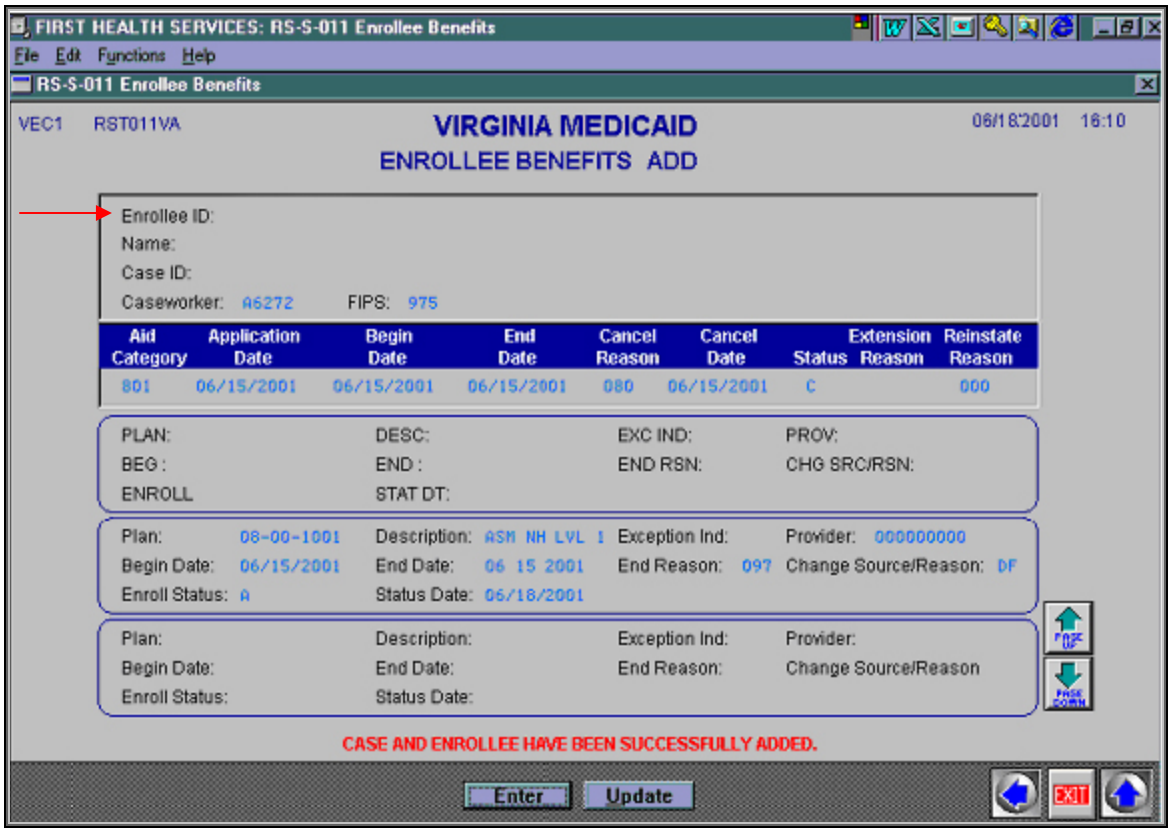
- Aid Category:
  - Enter *801* for Level 1 screening.
  - Enter *802* for Level 2 screening. If both Levels 1 and 2 were done, use 802.
  - Enter *803* for ALF (Assisted Living Facilities).
- Application Date – Enter the date the screener signed the form.
- Begin Date – Enter the date the screener signed the form.
- End date – Leave blank. The system will supply the date.

16. Choose **Enter**. If no errors, the system will display the **Benefits** screen to show the benefits approved for the enrollee.



17. Verify the information entered. If there are errors, page back to the previous screen to correct the errors.

18. Choose **Update** to post the data.



19. The screen will be returned with the enrollee ID number that has been assigned by the system.
20. Write the enrollee ID number on the Assessment form and return to the **Assessment** screen to key the assessment.

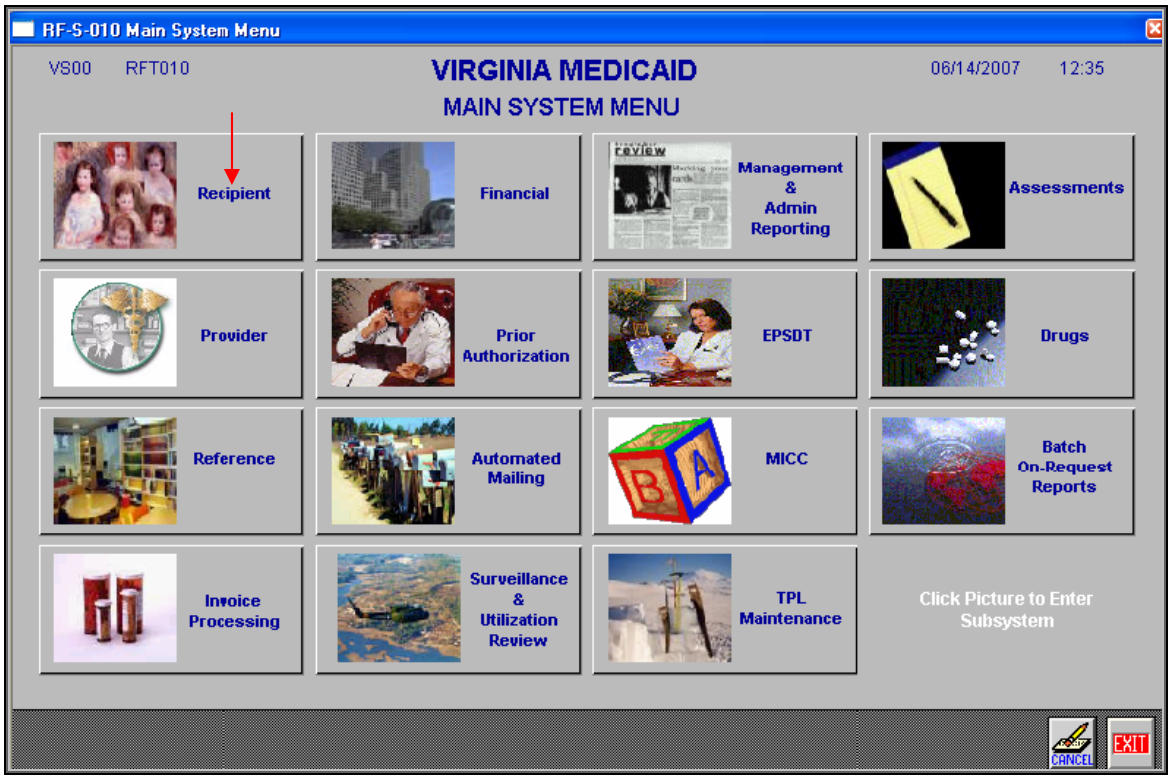
5.2 Adding a New Eligibility Segment for Canceled Enrollee

To add a new eligibility segment to the Enrollment File for a person who is on file but not eligible on the date of screening, you must use the following MMIS screens:

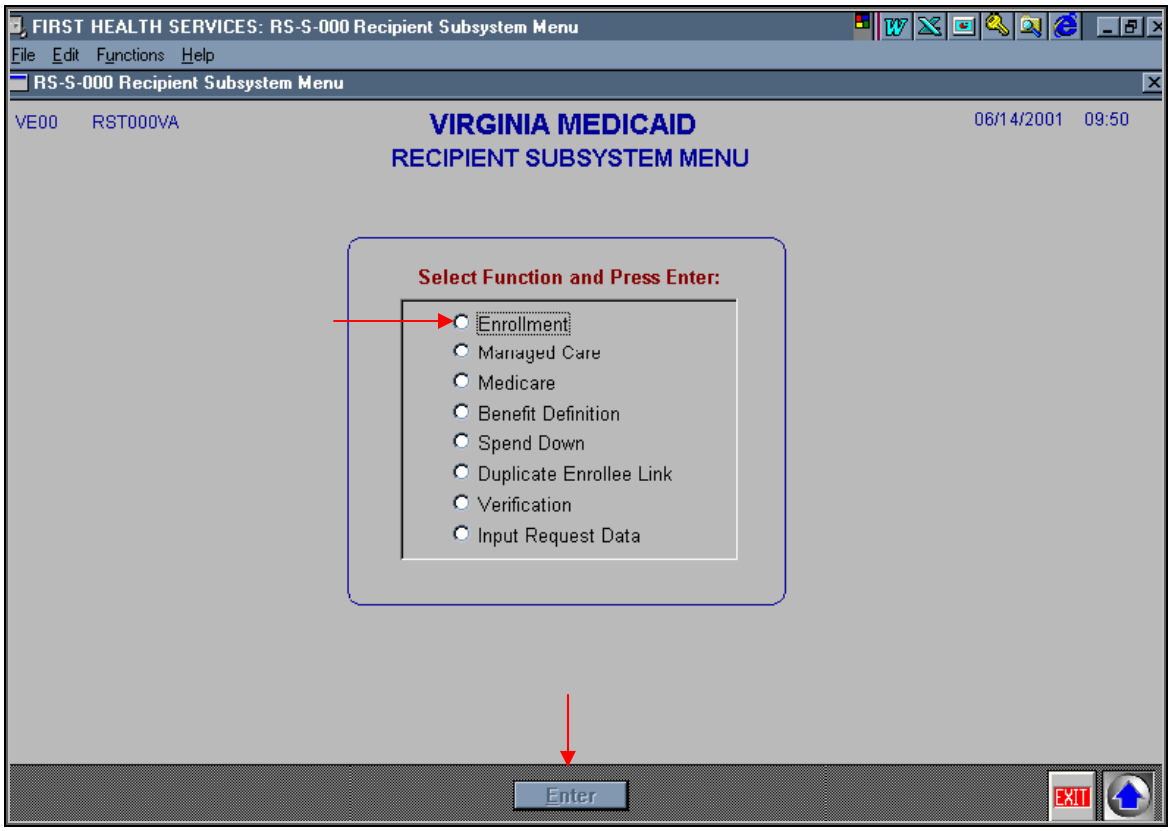
- Recipient Subsystem Menu (RS-S-000)
- Enrollment Menu (RS-S-001)
- Eligibility Data – UPDATE (RS-S-015)
- Enrollee Benefits – UPDATE (RS-S-011)

Procedure

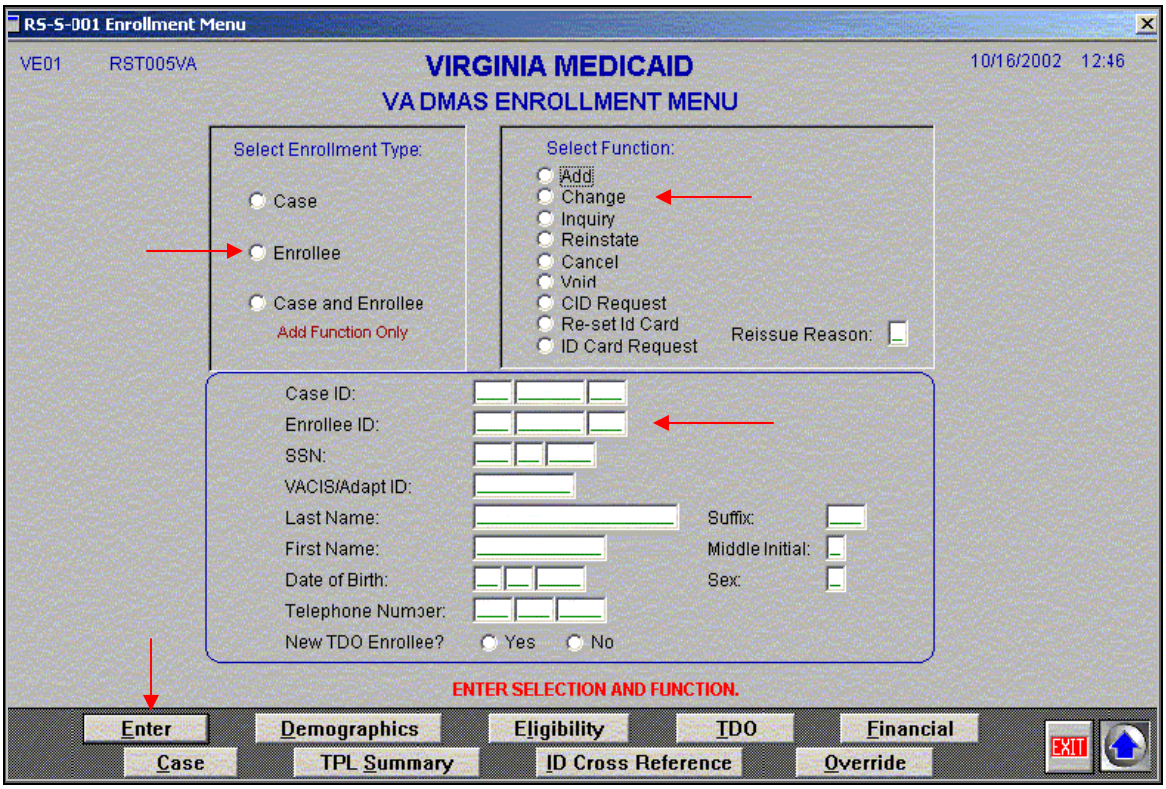
1. Access the **MMIS Main Menu** screen.



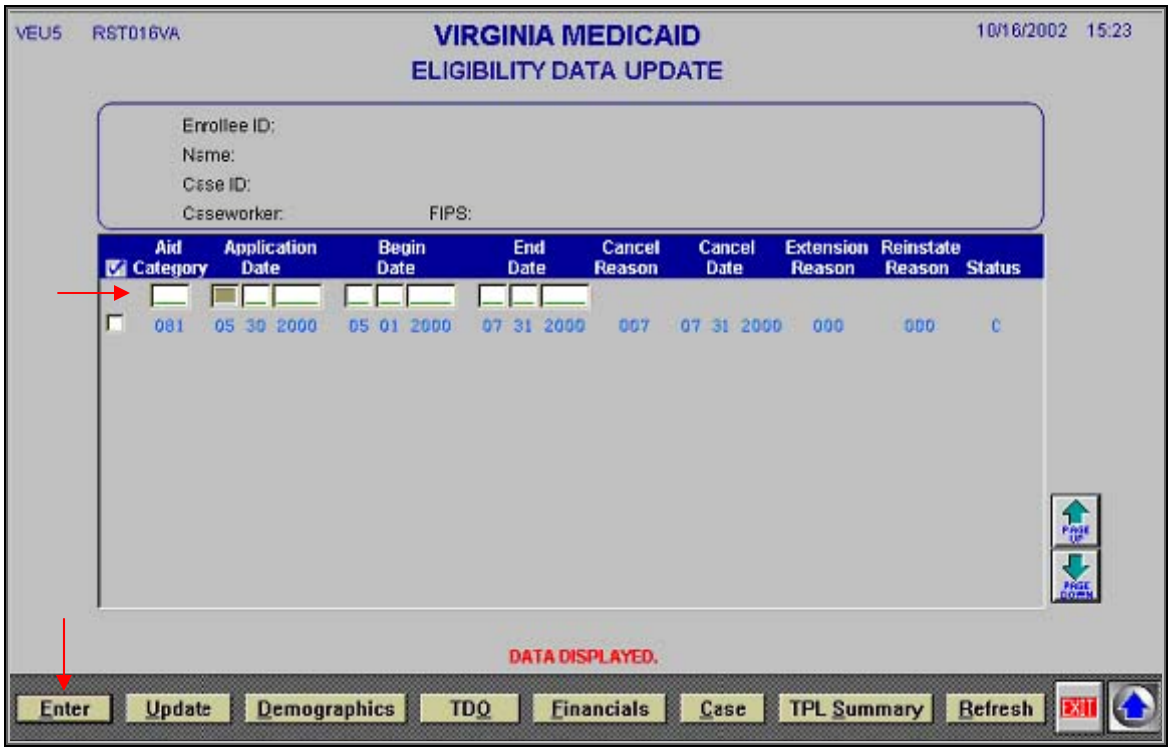
2. Click on the **Recipient** icon.



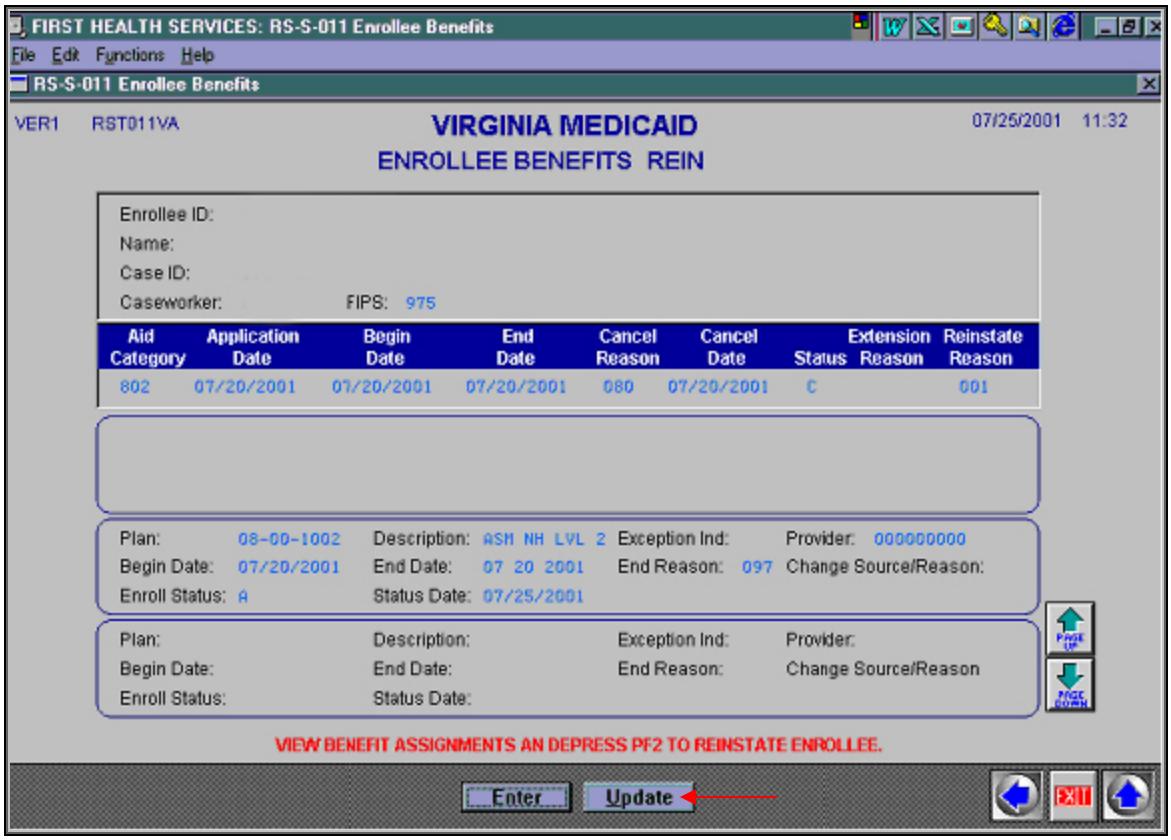
3. Select **Enrollment**.
4. Choose **Enter**.



5. Select **Enrollee**.
6. Select **Change**.
7. Enter the Enrollee ID.
8. Choose **Enter**.



9. Enter data as shown on the sample:
   - ❖ Aid Category:
     - – Enter *801* for Level 1 screening.
     - – Enter *802* for Level 2 screening. If both Levels 1 and 2 were done, use 802.
     - – Enter *803* for ALF (Assisted Living Facilities).
   - ❖ Application Date – Enter the date the screener signed the form.
   - ❖ Begin Date – Enter the date the screener signed the form.
   - ❖ End date – Leave blank. The system will supply the date.
10. Choose **Enter**. If no errors, the system will display the **Benefits** screen to show the benefits approved for the enrollee.



11. Verify the information entered. If there are errors, page back to the previous screen to correct the errors.
12. Choose **Update** to post the data.

5.3 Change an Enrollee's Record

If you see an error message **Enrollee not Medicaid Eligible** or **Not Medicaid Eligible on the Day of Screening** while attempting to reinstate an enrollee. Follow the steps outlined below.

Procedure

1. Access the **MMIS Main Menu** screen.
2. Click on the **Recipient** icon.
3. Click on **Enrollment**. Click **Enter**.
4. Is there is a Medicaid number on the DMAS-96 form?

   Yes! Click on the box next to the **Enrollee ID** field, then choose **Enter**. Then, go to sep 5 below.

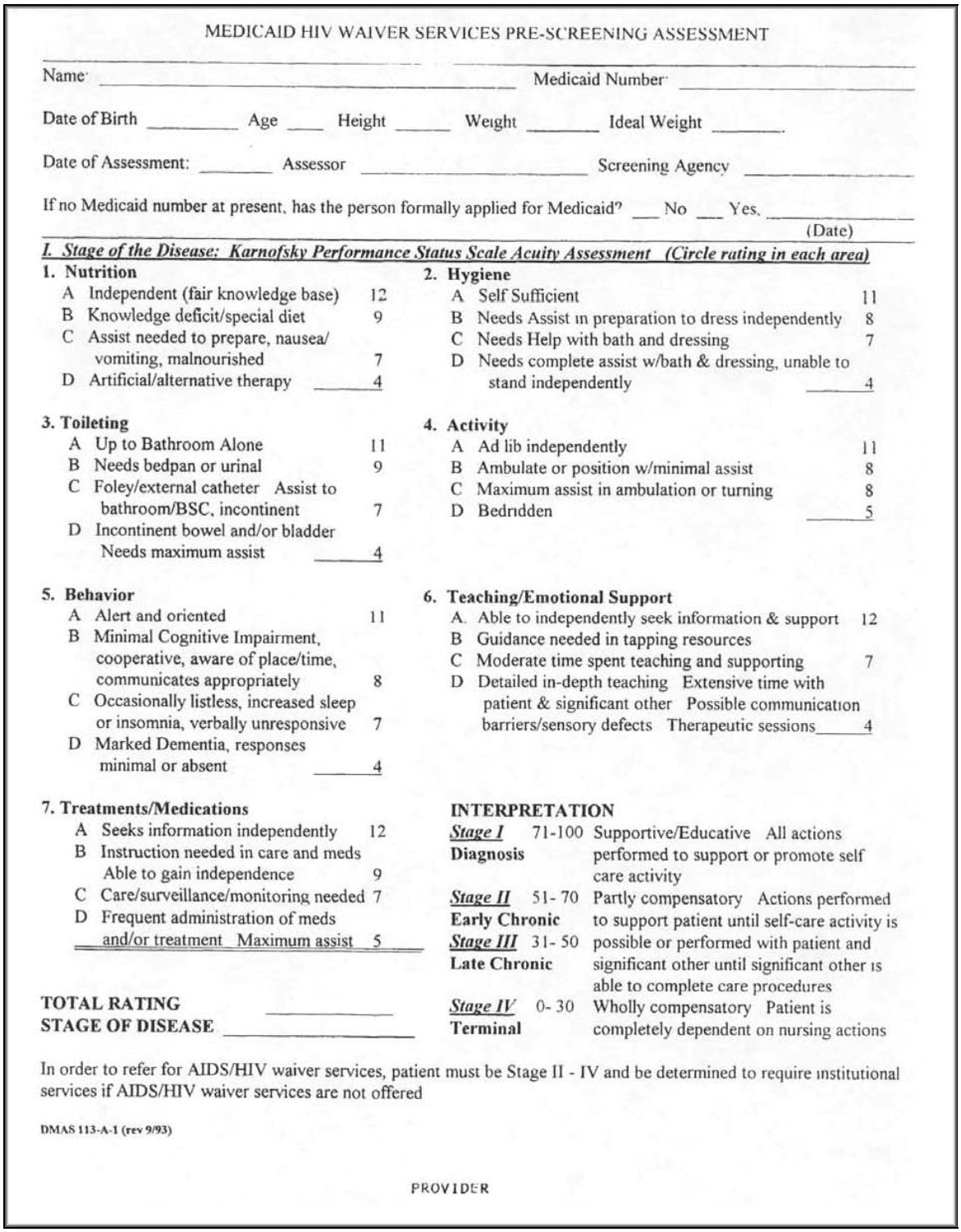
   No! Do not select anything in the **Select Function** box. Just key in the Social Security

Number or last name and first name. Then Choose **Enter**. If the record is found, go to step 5 below

5. Choose the box next to the Enrollee ID number, then choose **Enter**.
6. Select the **Enrollee** radio button in the **Select Enrollment Type** panel.
7. Choose the **Change** radio button in the **Select Function** panel.
8. Choose the **Enter** button.
9. Choose the **Eligibility** button.
10. You see the **Eligilbility Benefit Update** screen.
11. Under Aid Category:
    - ❖ Enter *801* for a Level 1 screening.
    - ❖ Enter *802* for a Level 2 screening.
    - ❖ Enter *803* for an ALF (Assisted Living Facility) ACR.
12. In the **Application Date** field, enter the date the screener signed the form.
13. In the **Begin Date** field, enter the application date.
14. Choose **Enter**.
15. If no errors appear, choose the **Update** button.

Appendix A Assessment Forms

Forms in this Appendix	
Form Name	**Page**



MEDICAID HIV WAIVER SERVICES PRE-SCREENING ASSESSMENT

Name: _____ Medicaid Number: _____

Date of Birth _____ Age ____ Height _____ Weight _____ Ideal Weight _____

Date of Assessment: _____ Assessor _____ Screening Agency _____

If no Medicaid number at present, has the person formally applied for Medicaid? ___ No ___ Yes, _____ (Date)

I. Stage of the Disease: Karnofsky Performance Status Scale Acuity Assessment (Circle rating in each area)

1. Nutrition
- A Independent (fair knowledge base) 12
- B Knowledge deficit/special diet 9
- C Assist needed to prepare, nausea/ vomiting, malnourished 7
- D Artificial/alternative therapy 4

2. Hygiene
- A Self Sufficient 11
- B Needs Assist in preparation to dress independently 8
- C Needs Help with bath and dressing 7
- D Needs complete assist w/bath & dressing, unable to stand independently 4

3. Toileting
- A Up to Bathroom Alone 11
- B Needs bedpan or urinal 9
- C Foley/external catheter Assist to bathroom/BSC, incontinent 7
- D Incontinent bowel and/or bladder Needs maximum assist 4

4. Activity
- A Ad lib independently 11
- B Ambulate or position w/minimal assist 8
- C Maximum assist in ambulation or turning 8
- D Bedridden 5

5. Behavior
- A Alert and oriented 11
- B Minimal Cognitive Impairment, cooperative, aware of place/time, communicates appropriately 8
- C Occasionally listless, increased sleep or insomnia, verbally unresponsive 7
- D Marked Dementia, responses minimal or absent 4

6. Teaching/Emotional Support
- A. Able to independently seek information & support 12
- B Guidance needed in tapping resources
- C Moderate time spent teaching and supporting 7
- D Detailed in-depth teaching Extensive time with patient & significant other Possible communication barriers/sensory defects Therapeutic sessions 4

7. Treatments/Medications
- A Seeks information independently 12
- B Instruction needed in care and meds Able to gain independence 9
- C Care/surveillance/monitoring needed 7
- D Frequent administration of meds and/or treatment Maximum assist 5

INTERPRETATION

Stage I **Diagnosis**	71-100	Supportive/Educative All actions performed to support or promote self care activity
Stage II **Early Chronic**	51- 70	Partly compensatory Actions performed to support patient until self-care activity is possible or performed with patient and significant other until significant other is able to complete care procedures
Stage III **Late Chronic**	31- 50	
Stage IV **Terminal**	0- 30	Wholly compensatory Patient is completely dependent on nursing actions

TOTAL RATING _____

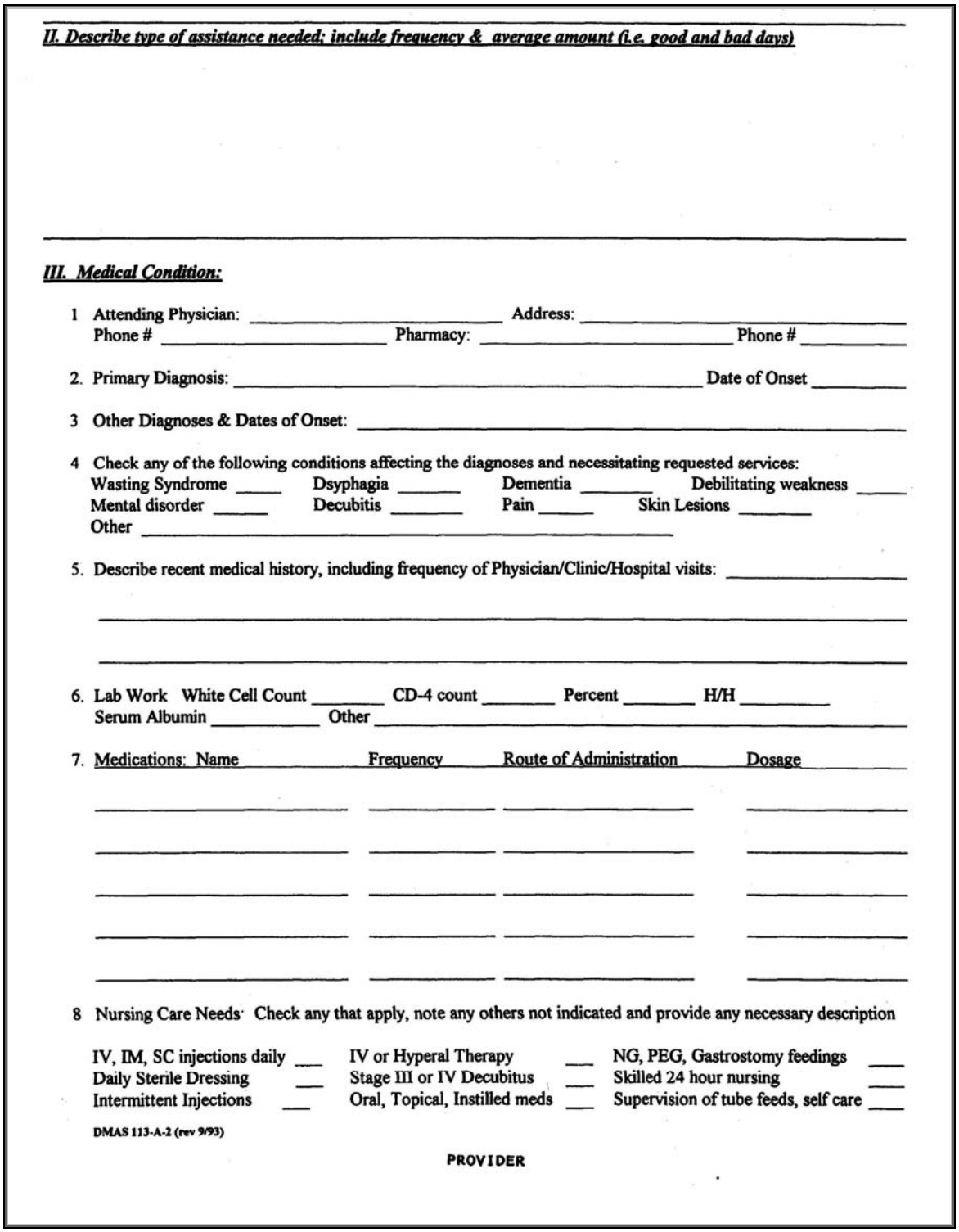
STAGE OF DISEASE _____

In order to refer for AIDS/HIV waiver services, patient must be Stage II - IV and be determined to require institutional services if AIDS/HIV waiver services are not offered

DMAS 113-A-1 (rev 9/93)

PROVIDER

Sample DMAS 113A – Medicaid HIV Waiver Services Pre-Screening Assessment



II. Describe type of assistance needed; include frequency & average amount (i.e. good and bad days)

III. Medical Condition:

1 Attending Physician: _____ Address: _____
Phone # _____ Pharmacy: _____ Phone # _____

2. Primary Diagnosis: _____ Date of Onset _____

3 Other Diagnoses & Dates of Onset: _____

4 Check any of the following conditions affecting the diagnoses and necessitating requested services:
Wasting Syndrome _____ Dsyphagia _____ Dementia _____ Debilitating weakness _____
Mental disorder _____ Decubitis _____ Pain _____ Skin Lesions _____
Other _____

5. Describe recent medical history, including frequency of Physician/Clinic/Hospital visits: _____

6. Lab Work White Cell Count _____ CD-4 count _____ Percent _____ H/H _____
Serum Albumin _____ Other _____

7. Medications: Name Frequency Route of Administration Dosage

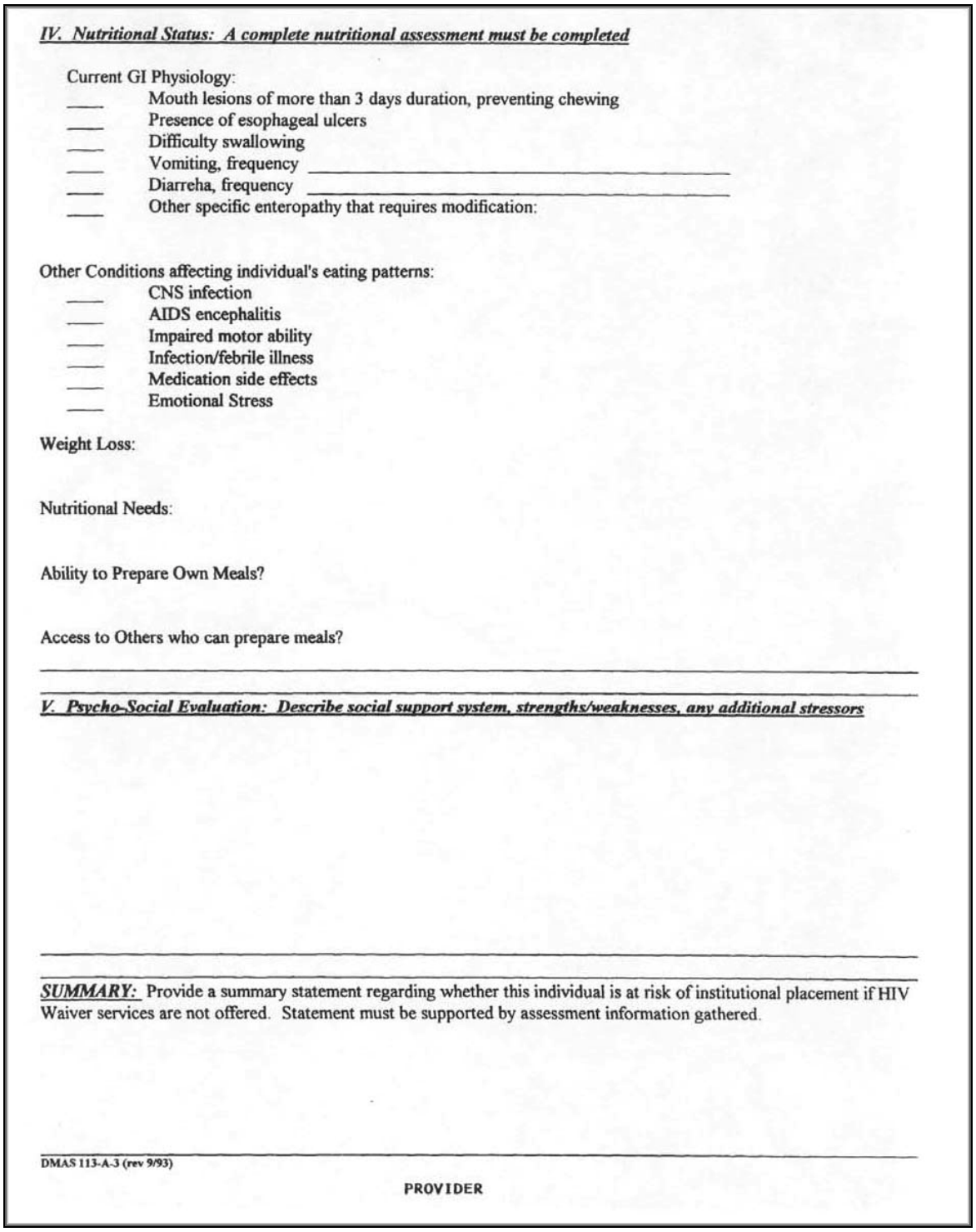
8 Nursing Care Needs· Check any that apply, note any others not indicated and provide any necessary description

IV, IM, SC injections daily ___	IV or Hyperal Therapy ___	NG, PEG, Gastrostomy feedings ___
Daily Sterile Dressing ___	Stage III or IV Decubitus ___	Skilled 24 hour nursing ___
Intermittent Injections ___	Oral, Topical, Instilled meds ___	Supervision of tube feeds, self care ___

DMAS 113-A-2 (rev 9/93)

PROVIDER

Sample DMAS 113A Medicaid HIV Waiver Services Pre-Screening Assessment



IV. Nutritional Status: A complete nutritional assessment must be completed

Current GI Physiology:

____ Mouth lesions of more than 3 days duration, preventing chewing
____ Presence of esophageal ulcers
____ Difficulty swallowing
____ Vomiting, frequency _____
____ Diarreha, frequency _____
____ Other specific enteropathy that requires modification:

Other Conditions affecting individual's eating patterns:

____ CNS infection
____ AIDS encephalitis
____ Impaired motor ability
____ Infection/febrile illness
____ Medication side effects
____ Emotional Stress

Weight Loss:

Nutritional Needs:

Ability to Prepare Own Meals?

Access to Others who can prepare meals?

_____

V. Psycho-Social Evaluation: Describe social support system, strengths/weaknesses, any additional stressors

_____

SUMMARY: Provide a summary statement regarding whether this individual is at risk of institutional placement if HIV Waiver services are not offered. Statement must be supported by assessment information gathered.

_____

DMAS 113-A-3 (rev 9/93)

PROVIDER

Sample DMAS 113A Medicaid HIV Waiver Services Pre-Screening Assessment

MEDICAID HIV WAIVER SERVICES PRE-SCREENING PLAN OF CARE

Name: _____ Medicaid Number: _____

I. SERVICE NEEDS: Note services currently received & who is providing & services needed & potential provider

Service Area	Currently Received	Provider	Service Needed	Refer To Provider
Activities of Daily Living				
Housekeeping				
Living Space				
Meals/Nutritional Supp.				
Shopping/Laundry				
Transportation				
Supervision				
Medicine Administration				
Financial				
Legal Services				
Child Care				
Foster Care				
Dental				
Counseling/Therapy				
Substance Abuse Treatment				
Health Education				
Support Groups				
Buddies/Companions				
Home Health				
Rehabilitation				
Outpatient Clinic				
Equipment/Supplies				
Physician				
Hospice				
Laboratory Services				
Other				

II. MEDICAID HIV WAIVER SERVICES: The following services are authorized to prevent institutionalization

CASE MANAGEMENT: ____ Provider: _____ Date Referred: _____

NUTRITIONAL SUPPLEMENTS: ____Physician's Order Attached _____ Authorization Form to Recipient ____

PERSONAL CARE. ____ Provider. _____ Date Referred _____

PRIVATE DUTY NURSING ____ Provider _____ Date Referred _____

RESPITE CARE. ____ Reason Requested: _____

Provider: _____ Type of Respite: ___Aide ___LPN ___ RN Date Requested____

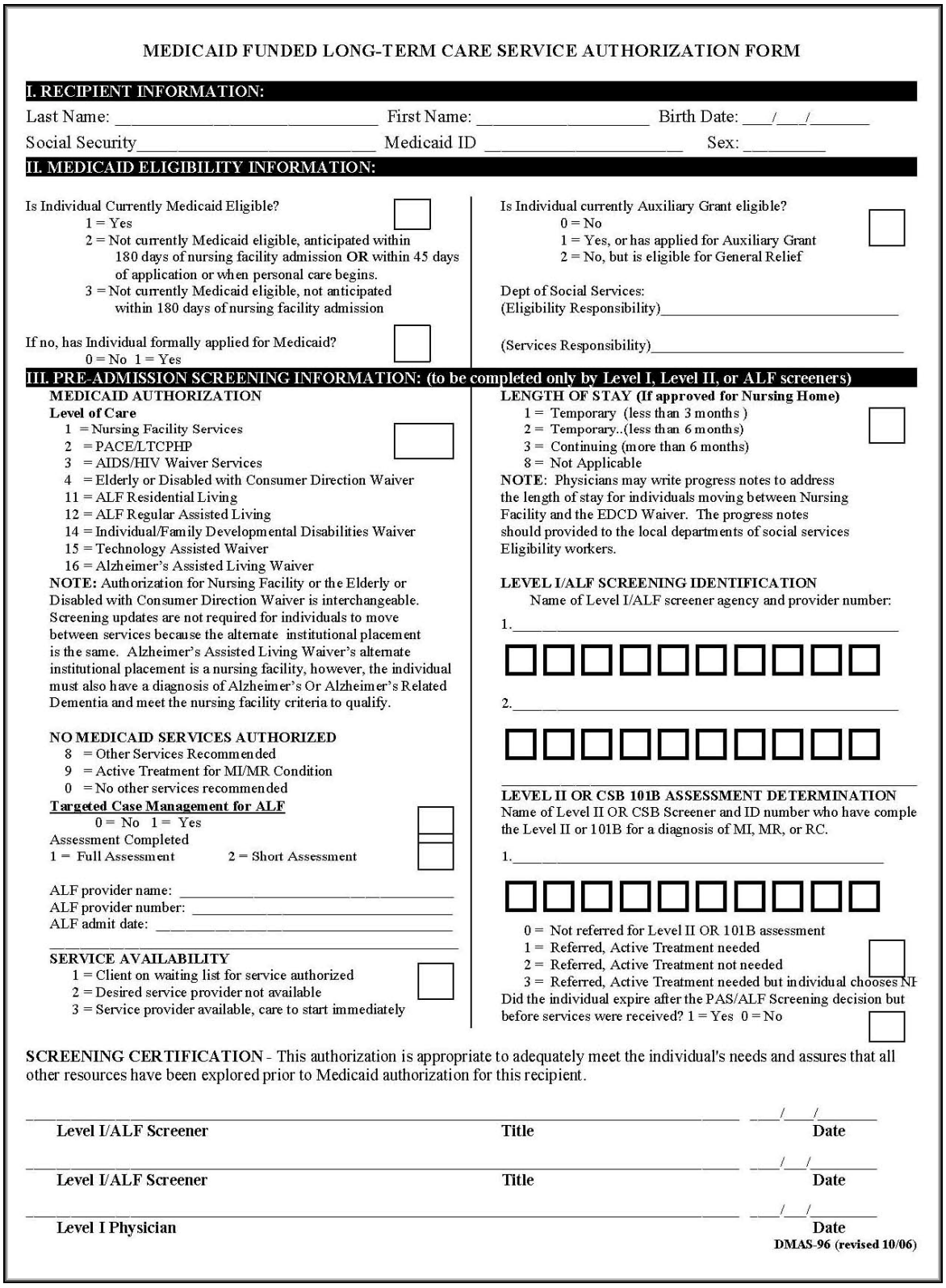
I have been informed of the available choice of providers and have chosen the providers noted above:

Medicaid Recipient _____ Date _____ PAS Staff _____ Date _____

DMAS 113-B (rev 9/93)

PROVIDER COPY

Sample DMAS 113B Medicaid HIV Waiver Services Plan of Care



MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ___/___/_____

Social Security_____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible?
1 = Yes
2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.
3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid?
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible?
0 = No
1 = Yes, or has applied for Auxiliary Grant
2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION
Level of Care
1 = Nursing Facility Services
2 = PACE/LTCPHP
3 = AIDS/HIV Waiver Services
4 = Elderly or Disabled with Consumer Direction Waiver
11 = ALF Residential Living
12 = ALF Regular Assisted Living
14 = Individual/Family Developmental Disabilities Waiver
15 = Technology Assisted Waiver
16 = Alzheimer's Assisted Living Waiver

NOTE: Authorization for Nursing Facility or the Elderly or Disabled with Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same. Alzheimer's Assisted Living Waiver's alternate institutional placement is a nursing facility, however, the individual must also have a diagnosis of Alzheimer's Or Alzheimer's Related Dementia and meet the nursing facility criteria to qualify.

NO MEDICAID SERVICES AUTHORIZED
8 = Other Services Recommended
9 = Active Treatment for MI/MR Condition
0 = No other services recommended

Targeted Case Management for ALF
0 = No 1 = Yes
Assessment Completed
1 = Full Assessment 2 = Short Assessment

ALF provider name: _____
ALF provider number: _____
ALF admit date: _____

SERVICE AVAILABILITY
1 = Client on waiting list for service authorized
2 = Desired service provider not available
3 = Service provider available, care to start immediately

LENGTH OF STAY (If approved for Nursing Home)
1 = Temporary (less than 3 months)
2 = Temporary..(less than 6 months)
3 = Continuing (more than 6 months)
8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility and the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION
Name of Level I/ALF screener agency and provider number:

1._____

2._____

LEVEL II OR CSB 101B ASSESSMENT DETERMINATION
Name of Level II OR CSB Screener and ID number who have comple the Level II or 101B for a diagnosis of MI, MR, or RC.

1._____

0 = Not referred for Level II OR 101B assessment
1 = Referred, Active Treatment needed
2 = Referred, Active Treatment not needed
3 = Referred, Active Treatment needed but individual chooses NF

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I Physician **Date**

DMAS-96 (revised 10/06)

Sample DMAS 96 Medicaid Funded LTC Pre-Admission Screening Authorization

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen ___/___/___
Assessment ___/___/___
Reassessment ___/___/___

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ (Last) (First) (Middle Initial) **Client SSN:** ___-___-____

Address: _____ (Street) (City) (State) (Zip Code)

Phone: ( ) _____ **City/County Code:** _____ _____ _____

Directions to House: **Pets?**

Demographics

Birthdate: ___/___/___ (Month) (Day) (Year) **Age:** _____ **Sex:** ___ Male 0 ___ Female 1

Marital Status: ___ Married 0 ___ Widowed 1 ___ Separated 2 ___ Divorced 3 ___ Single 4 ___ Unknown 9

Race:
___ White 0
___ Black/African American 1
___ American Indian 2
___ Oriental/Asian 3
___ Alaskan Native 4
___ Unknown 9 _____
Ethnic Origin _____

Education:
___ Less than High School 0
___ Some High School 1
___ High School Graduate 2
___ Some College 3
___ College Graduate 4
___ Unknown 9
Specify _____

Communication of Needs:
___ Verbally, English 0
___ Verbally, Other Language 1
Specify _____
___ Sign Language/Gestures/Device 2
___ Does Not Communicate 3
Hearing Impaired? _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name of Primary Physician: _____ **Phone:** _____

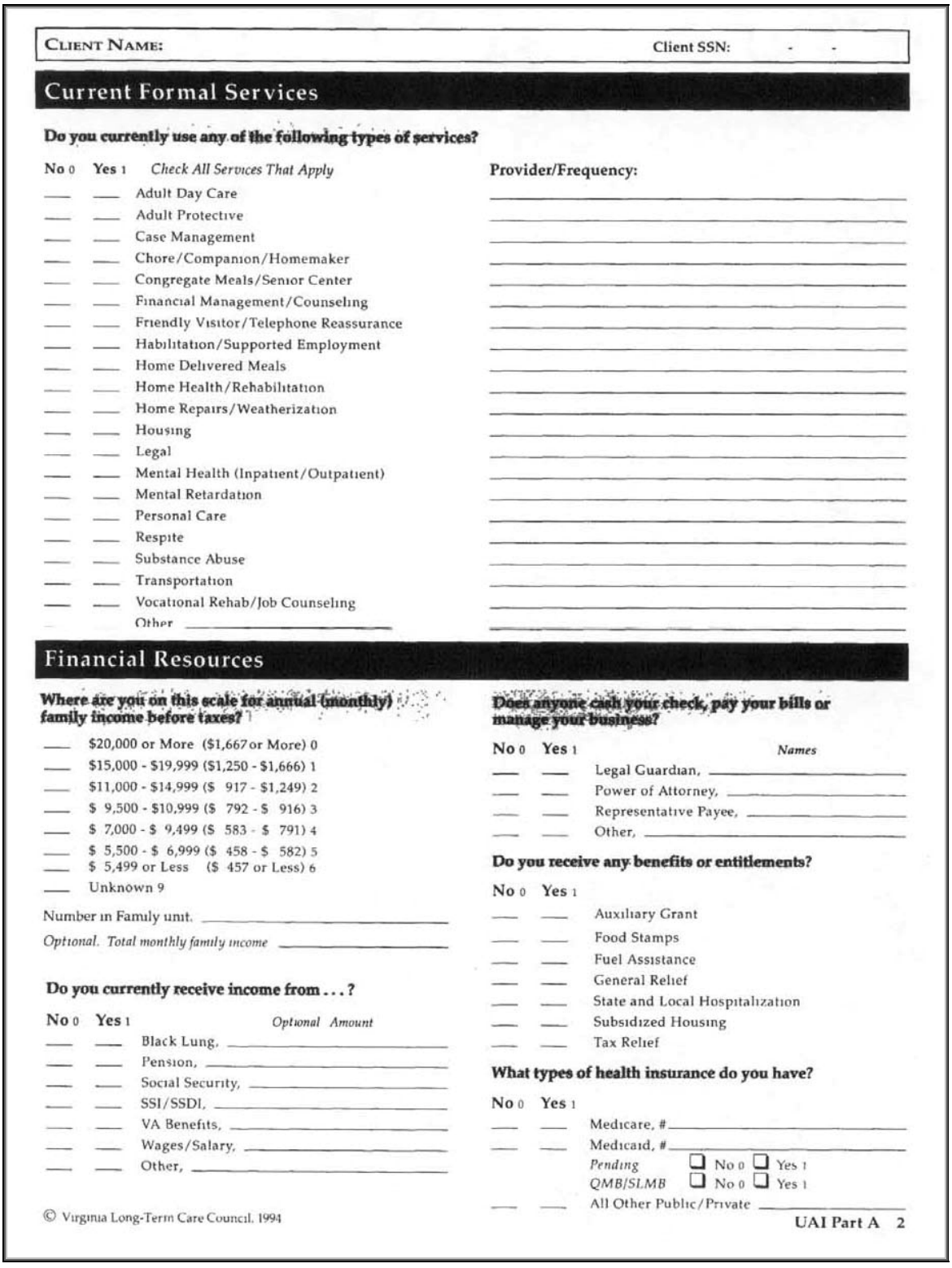
Address: _____

Initial Contact

Who called: _____ (Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*Check All Services That Apply*	Provider/Frequency:
___	___	Adult Day Care	
___	___	Adult Protective	
___	___	Case Management	
___	___	Chore/Companion/Homemaker	
___	___	Congregate Meals/Senior Center	
___	___	Financial Management/Counseling	
___	___	Friendly Visitor/Telephone Reassurance	
___	___	Habilitation/Supported Employment	
___	___	Home Delivered Meals	
___	___	Home Health/Rehabilitation	
___	___	Home Repairs/Weatherization	
___	___	Housing	
___	___	Legal	
___	___	Mental Health (Inpatient/Outpatient)	
___	___	Mental Retardation	
___	___	Personal Care	
___	___	Respite	
___	___	Substance Abuse	
___	___	Transportation	
___	___	Vocational Rehab/Job Counseling	
		Other ___	

Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

___ $20,000 or More ($1,667 or More) 0
___ $15,000 - $19,999 ($1,250 - $1,666) 1
___ $11,000 - $14,999 ($ 917 - $1,249) 2
___ $ 9,500 - $10,999 ($ 792 - $ 916) 3
___ $ 7,000 - $ 9,499 ($ 583 - $ 791) 4
___ $ 5,500 - $ 6,999 ($ 458 - $ 582) 5
___ $ 5,499 or Less ($ 457 or Less) 6
___ Unknown 9

Number in Family unit. ___

Optional. Total monthly family income ___

Do you currently receive income from . . . ?

No 0	Yes 1	*Optional Amount*
___	___	Black Lung, ___
___	___	Pension, ___
___	___	Social Security, ___
___	___	SSI/SSDI, ___
___	___	VA Benefits, ___
___	___	Wages/Salary, ___
___	___	Other, ___

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1	*Names*
___	___	Legal Guardian, ___
___	___	Power of Attorney, ___
___	___	Representative Payee, ___
___	___	Other, ___

Do you receive any benefits or entitlements?

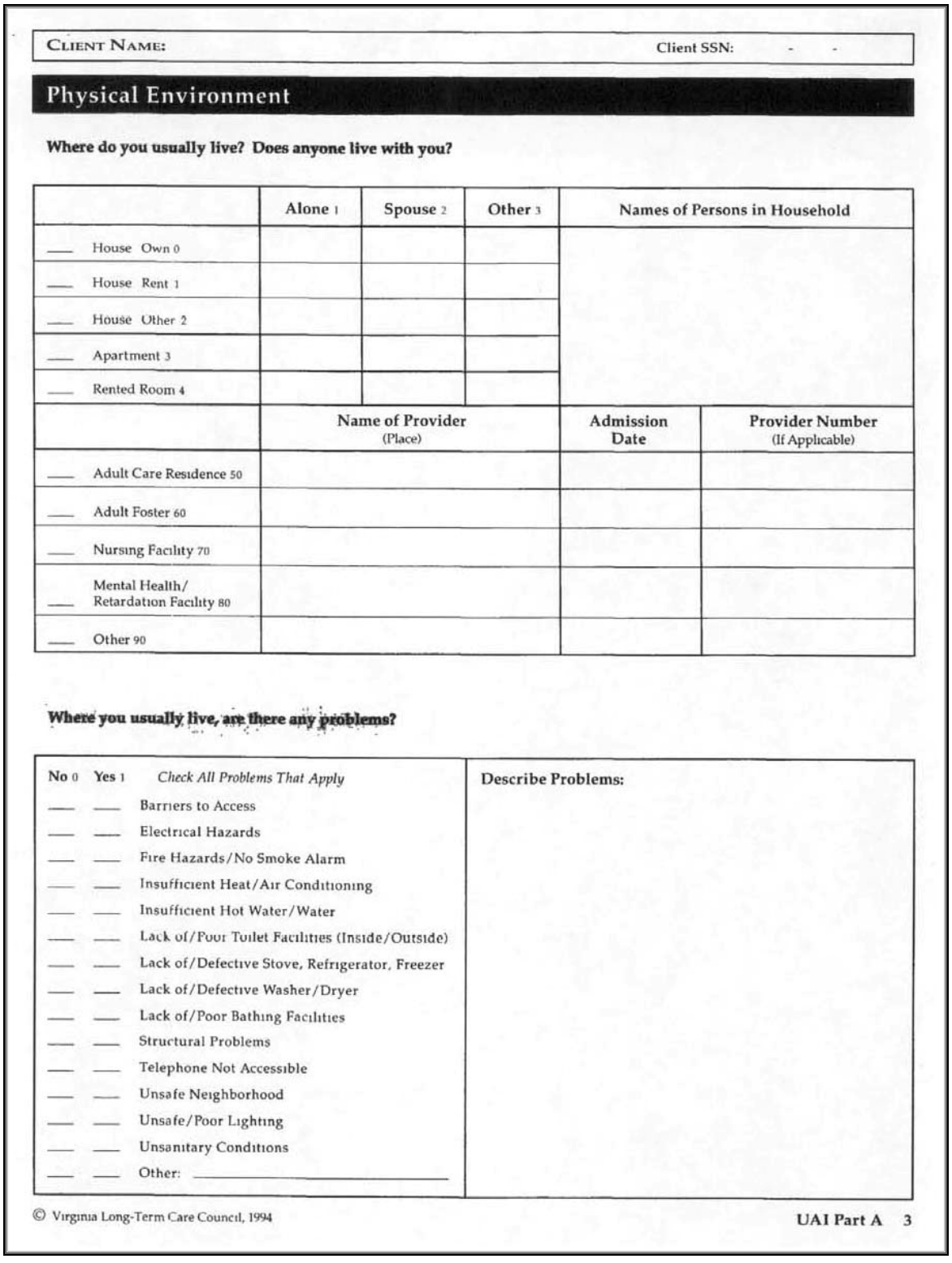
No 0	Yes 1	
___	___	Auxiliary Grant
___	___	Food Stamps
___	___	Fuel Assistance
___	___	General Relief
___	___	State and Local Hospitalization
___	___	Subsidized Housing
___	___	Tax Relief

What types of health insurance do you have?

No 0	Yes 1	
___	___	Medicare, # ___
___	___	Medicaid, # ___
		Pending ☐ No 0 ☐ Yes 1
		QMB/SLMB ☐ No 0 ☐ Yes 1
___	___	All Other Public/Private ___

UAI Part A 2

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
___ House Own 0				
___ House Rent 1				
___ House Other 2				
___ Apartment 3				
___ Rented Room 4				

	Name of Provider (Place)	Admission Date	Provider Number (If Applicable)
___ Adult Care Residence 50			
___ Adult Foster 60			
___ Nursing Facility 70			
___ Mental Health/ Retardation Facility 80			
___ Other 90			

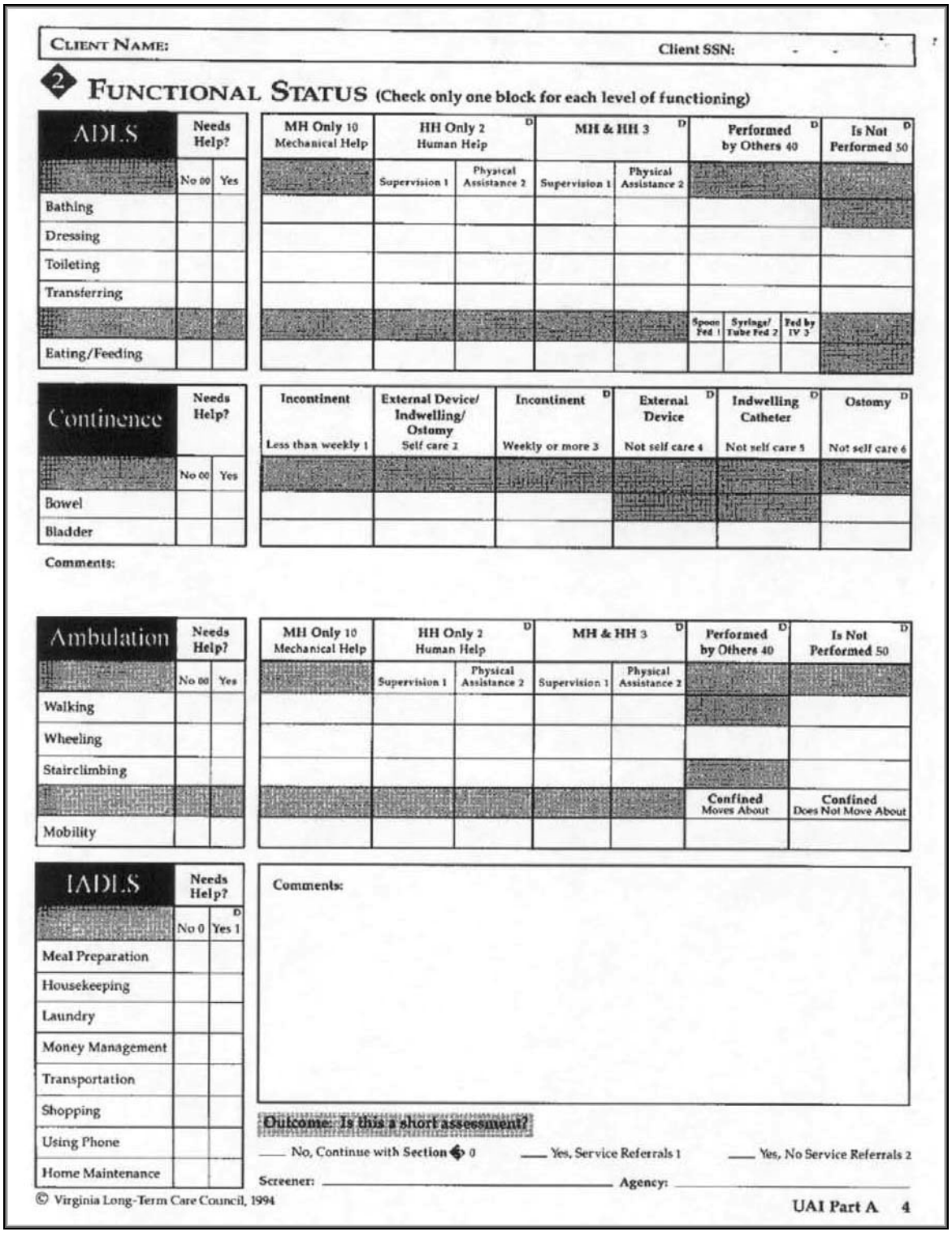
Where you usually live, are there any problems?

No 0	Yes 1	*Check All Problems That Apply*
___	___	Barriers to Access
___	___	Electrical Hazards
___	___	Fire Hazards/No Smoke Alarm
___	___	Insufficient Heat/Air Conditioning
___	___	Insufficient Hot Water/Water
___	___	Lack of/Poor Toilet Facilities (Inside/Outside)
___	___	Lack of/Defective Stove, Refrigerator, Freezer
___	___	Lack of/Defective Washer/Dryer
___	___	Lack of/Poor Bathing Facilities
___	___	Structural Problems
___	___	Telephone Not Accessible
___	___	Unsafe Neighborhood
___	___	Unsafe/Poor Lighting
___	___	Unsanitary Conditions
___	___	Other: _____

Describe Problems:

UAI Part A 3

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40			Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding											

Continence	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
	No 00	Yes						
Bowel								
Bladder								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

IADLS	Needs Help?	
	No 0	Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

___ No, Continue with Section ➔ 0 ___ Yes, Service Referrals 1 ___ Yes, No Service Referrals 2

Screener: _____ Agency: _____

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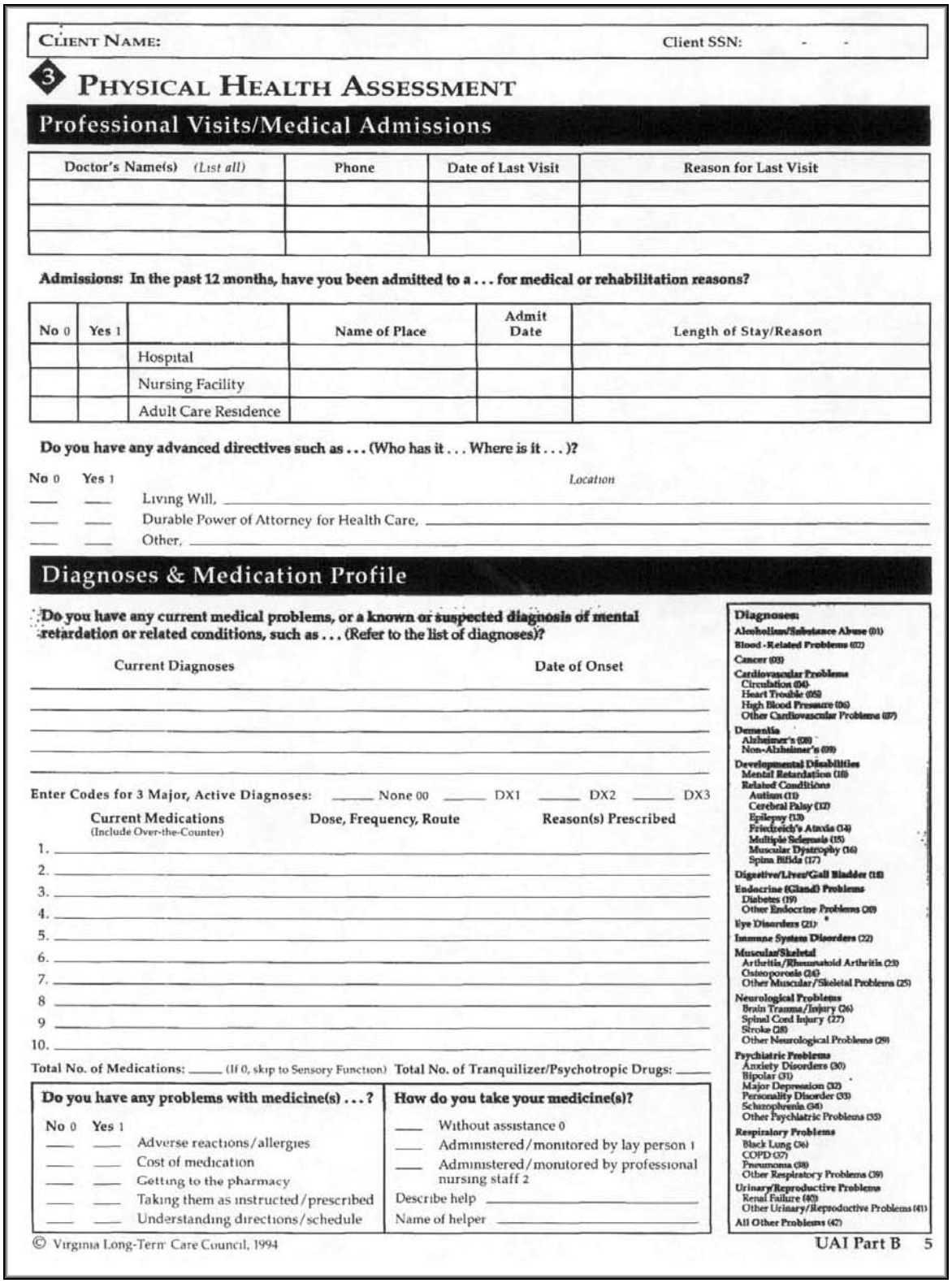
UAI Part A 4

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advanced directives such as . . . (Who has it . . . Where is it . . .)?

No 0 Yes 1 *Location*

___ ___ Living Will, _____

___ ___ Durable Power of Attorney for Health Care, _____

___ ___ Other, _____

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)?

Current Diagnoses — Date of Onset

_____

_____

_____

_____

_____

Enter Codes for 3 Major, Active Diagnoses: ____ None 00 ____ DX1 ____ DX2 ____ DX3

	Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8			
9			
10.			

Total No. of Medications: ____ (If 0, skip to Sensory Function) Total No. of Tranquilizer/Psychotropic Drugs: ____

Do you have any problems with medicine(s) . . . ?

No 0 Yes 1

___ ___ Adverse reactions/allergies

___ ___ Cost of medication

___ ___ Getting to the pharmacy

___ ___ Taking them as instructed/prescribed

___ ___ Understanding directions/schedule

How do you take your medicine(s)?

___ Without assistance 0

___ Administered/monitored by lay person 1

___ Administered/monitored by professional nursing staff 2

Describe help _____

Name of helper _____

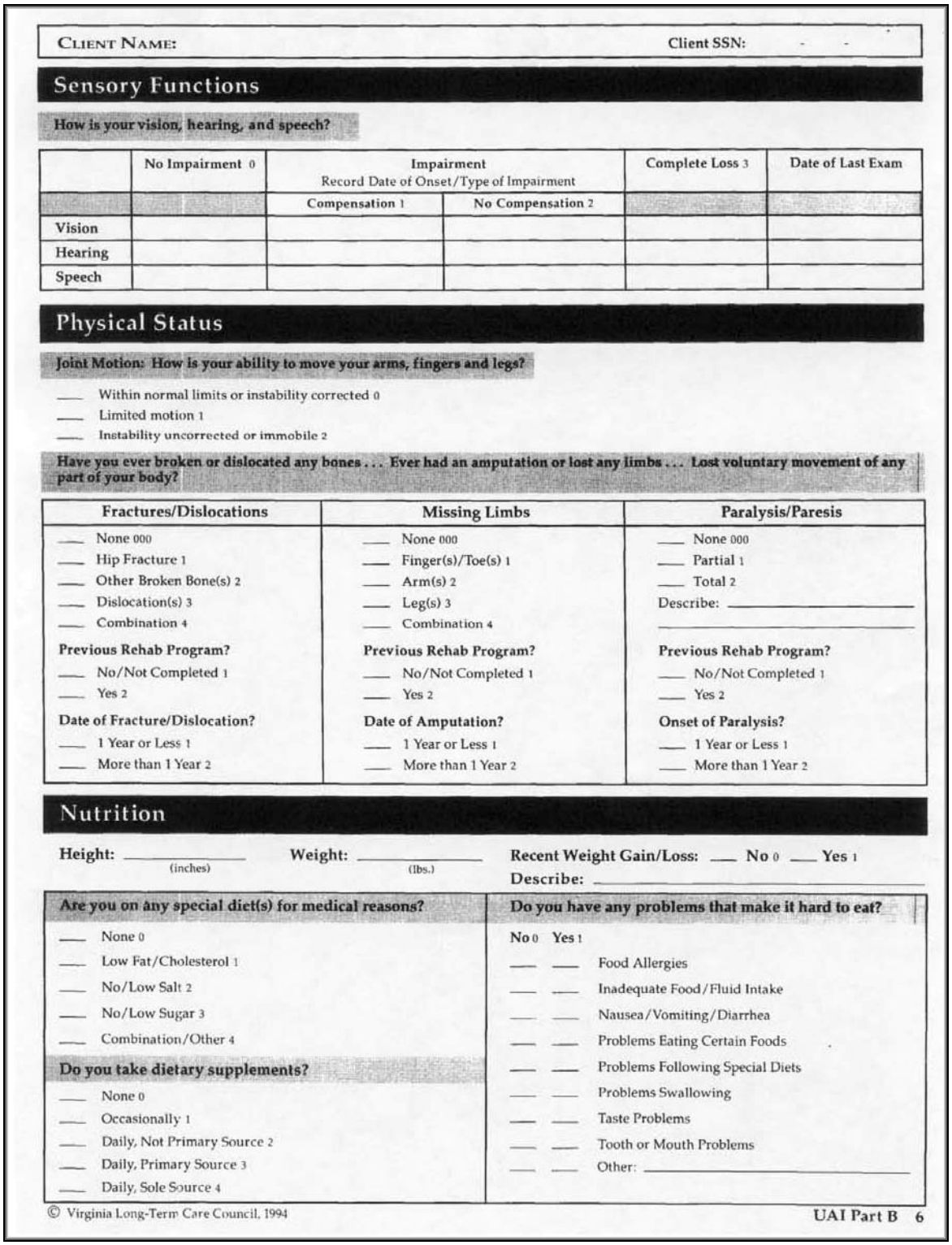
Diagnoses:

Alcoholism/Substance Abuse (01)
Blood-Related Problems (02)
Cancer (03)
Cardiovascular Problems
Circulation (04)
Heart Trouble (05)
High Blood Pressure (06)
Other Cardiovascular Problems (07)
Dementia
Alzheimer's (08)
Non-Alzheimer's (09)
Developmental Disabilities
Mental Retardation (10)
Related Conditions
Autism (11)
Cerebral Palsy (12)
Epilepsy (13)
Friedreich's Ataxia (14)
Multiple Sclerosis (15)
Muscular Dystrophy (16)
Spina Bifida (17)
Digestive/Liver/Gall Bladder (18)
Endocrine (Gland) Problems
Diabetes (19)
Other Endocrine Problems (20)
Eye Disorders (21)
Immune System Disorders (22)
Muscular/Skeletal
Arthritis/Rheumatoid Arthritis (23)
Osteoporosis (24)
Other Muscular/Skeletal Problems (25)
Neurological Problems
Brain Trauma/Injury (26)
Spinal Cord Injury (27)
Stroke (28)
Other Neurological Problems (29)
Psychiatric Problems
Anxiety Disorders (30)
Bipolar (31)
Major Depression (32)
Personality Disorder (33)
Schizophrenia (34)
Other Psychiatric Problems (35)
Respiratory Problems
Black Lung (36)
COPD (37)
Pneumonia (38)
Other Respiratory Problems (39)
Urinary/Reproductive Problems
Renal Failure (40)
Other Urinary/Reproductive Problems (41)
All Other Problems (42)

UAI Part B 5

Sample Virginia Uniform Assessment Instrument

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment Record Date of Onset/Type of Impairment		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
___ None 000	___ None 000	___ None 000
___ Hip Fracture 1	___ Finger(s)/Toe(s) 1	___ Partial 1
___ Other Broken Bone(s) 2	___ Arm(s) 2	___ Total 2
___ Dislocation(s) 3	___ Leg(s) 3	Describe: _____
___ Combination 4	___ Combination 4	_____
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
___ No/Not Completed 1	___ No/Not Completed 1	___ No/Not Completed 1
___ Yes 2	___ Yes 2	___ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
___ 1 Year or Less 1	___ 1 Year or Less 1	___ 1 Year or Less 1
___ More than 1 Year 2	___ More than 1 Year 2	___ More than 1 Year 2

Nutrition

Height: _____ (inches) **Weight:** _____ (lbs.) **Recent Weight Gain/Loss:** ___ No 0 ___ Yes 1
Describe: _____

Are you on any special diet(s) for medical reasons?

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

Do you take dietary supplements?

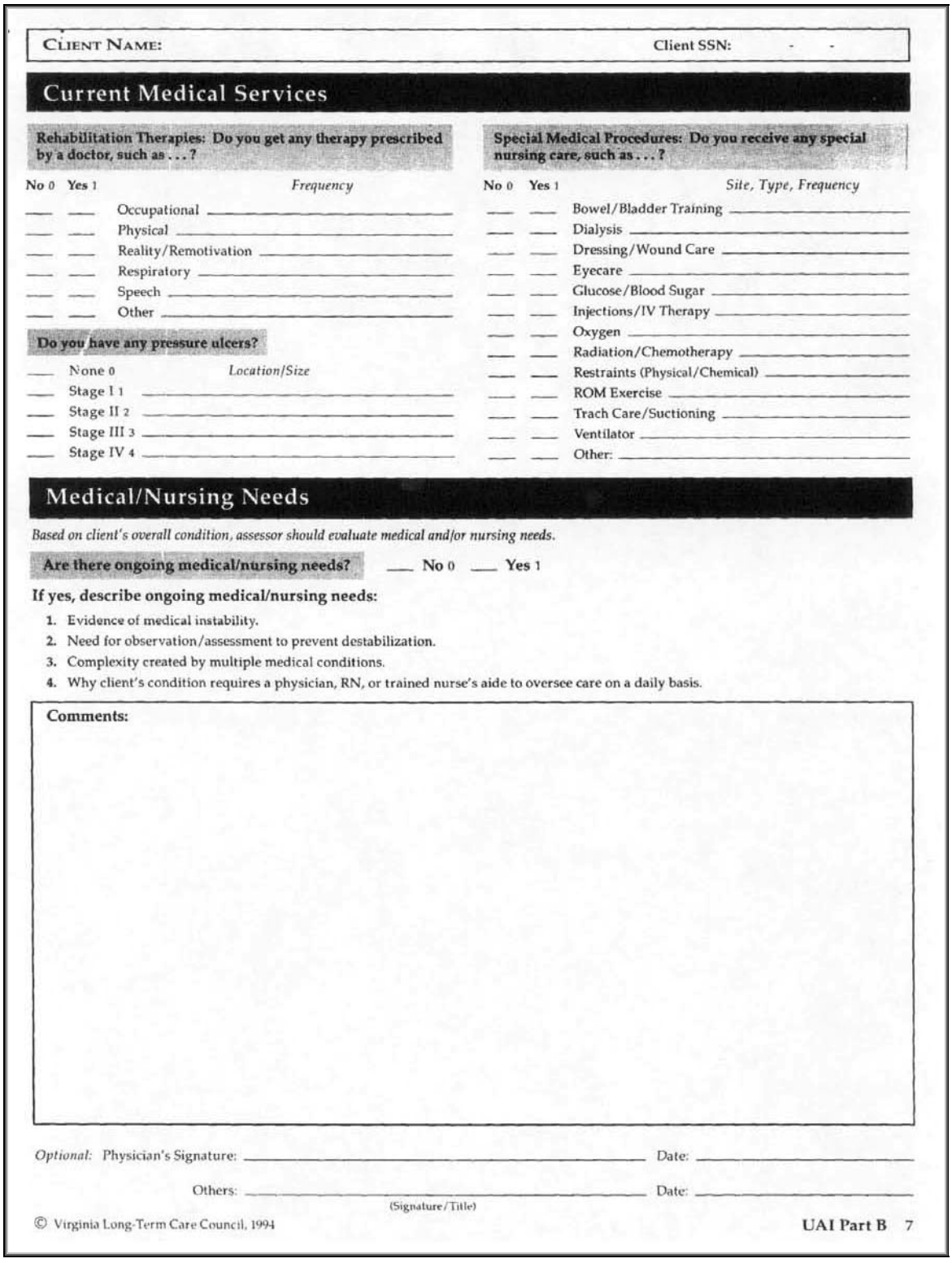
___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
___	___	Food Allergies
___	___	Inadequate Food/Fluid Intake
___	___	Nausea/Vomiting/Diarrhea
___	___	Problems Eating Certain Foods
___	___	Problems Following Special Diets
___	___	Problems Swallowing
___	___	Taste Problems
___	___	Tooth or Mouth Problems
___	___	Other: _____

UAI Part B 6

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . ?

No 0	Yes 1		*Frequency*
___	___	Occupational	
___	___	Physical	
___	___	Reality/Remotivation	
___	___	Respiratory	
___	___	Speech	
___	___	Other	

Do you have any pressure ulcers?

		Location/Size
___	None 0	
___	Stage I 1	
___	Stage II 2	
___	Stage III 3	
___	Stage IV 4	

Special Medical Procedures: Do you receive any special nursing care, such as . . . ?

No 0	Yes 1		*Site, Type, Frequency*
___	___	Bowel/Bladder Training	
___	___	Dialysis	
___	___	Dressing/Wound Care	
___	___	Eyecare	
___	___	Glucose/Blood Sugar	
___	___	Injections/IV Therapy	
___	___	Oxygen	
___	___	Radiation/Chemotherapy	
___	___	Restraints (Physical/Chemical)	
___	___	ROM Exercise	
___	___	Trach Care/Suctioning	
___	___	Ventilator	
___	___	Other:	

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ___ No 0 ___ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

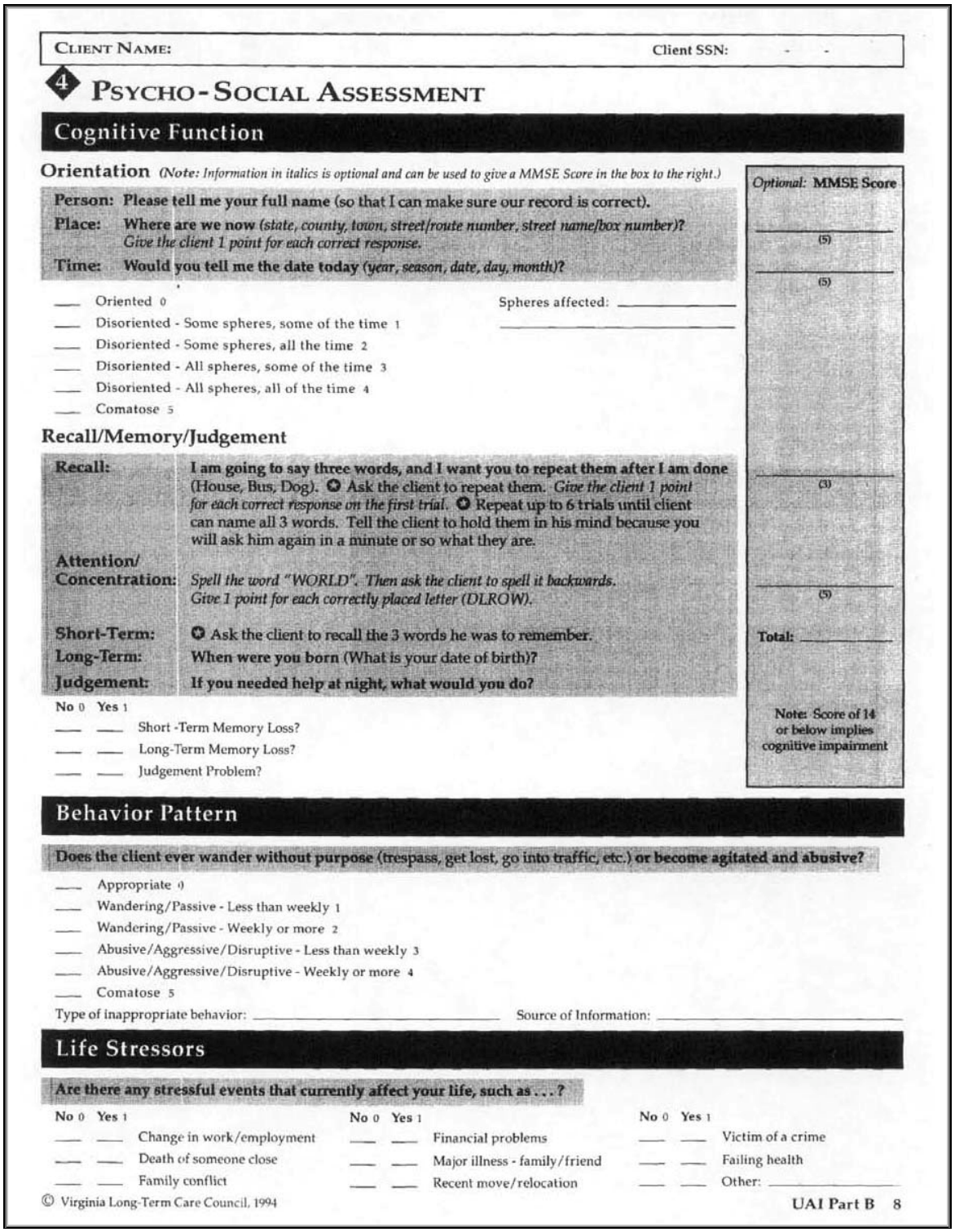
Comments:

Optional: Physician's Signature: _____ Date: _____

Others: _____ Date: _____
(Signature/Title)

UAI Part B 7

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: **Please tell me your full name** (so that I can make sure our record is correct).

Place: **Where are we now** *(state, county, town, street/route number, street name/box number)?* *Give the client 1 point for each correct response.*

Time: **Would you tell me the date today** *(year, season, date, day, month)?*

Optional: **MMSE Score**

(5)

(5)

(3)

(5)

Total:

Note: Score of 14 or below implies cognitive impairment

___ Oriented 0

___ Disoriented - Some spheres, some of the time 1

___ Disoriented - Some spheres, all the time 2

___ Disoriented - All spheres, some of the time 3

___ Disoriented - All spheres, all of the time 4

___ Comatose 5

Spheres affected: _____

Recall/Memory/Judgement

Recall: **I am going to say three words, and I want you to repeat them after I am done** (House, Bus, Dog). ✪ Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* ✪ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: ✪ Ask the client to recall the 3 words he was to remember.

Long-Term: **When were you born** (What is your date of birth)?

Judgement: **If you needed help at night, what would you do?**

No 0	Yes 1	
___	___	Short -Term Memory Loss?
___	___	Long-Term Memory Loss?
___	___	Judgement Problem?

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) **or become agitated and abusive?**

___ Appropriate 0

___ Wandering/Passive - Less than weekly 1

___ Wandering/Passive - Weekly or more 2

___ Abusive/Aggressive/Disruptive - Less than weekly 3

___ Abusive/Aggressive/Disruptive - Weekly or more 4

___ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
___	___	Change in work/employment	___	___	Financial problems	___	___	Victim of a crime
___	___	Death of someone close	___	___	Major illness - family/friend	___	___	Failing health
___	___	Family conflict	___	___	Recent move/relocation	___	___	Other: _____

UAI Part B 8

Sample Virginia Uniform Assessment Instrument

CLIENT NAME: Client SSN: - -

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you didn't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living . . . or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite . . . that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1 *Describe*

___ ___ Solitary Activities, _____

___ ___ With Friends/Family, _____

___ ___ With Groups/Clubs, _____

___ ___ Religious Activities, _____

How often do you talk with your children, family or friends, either during a visit or over the phone?

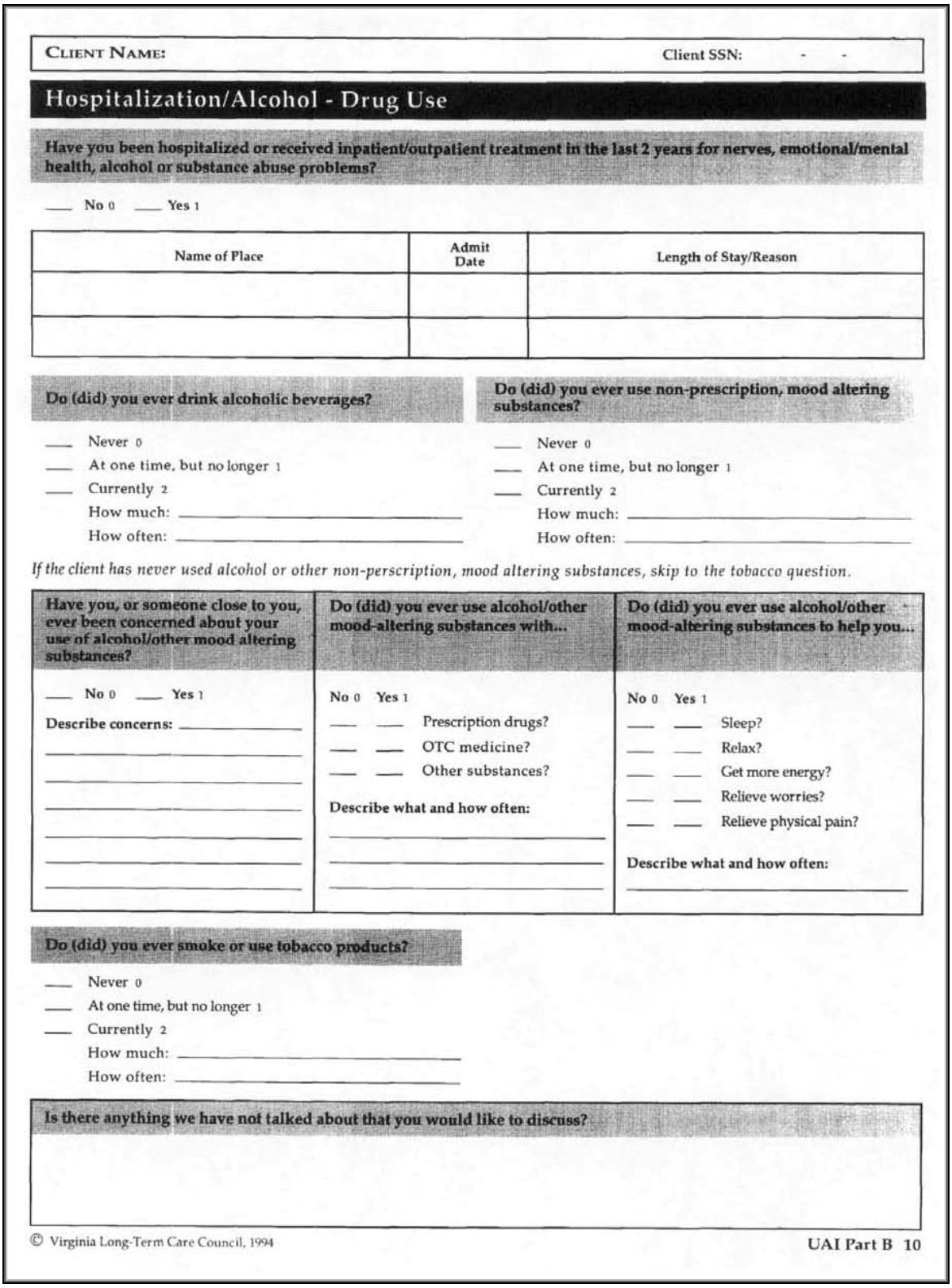
Children	Other Family	Friends/Neighbors
___ No Children 0	___ No Other Family 0	___ No Friends/Neighbors 0
___ Daily 1	___ Daily 1	___ Daily 1
___ Weekly 2	___ Weekly 2	___ Weekly 2
___ Monthly 3	___ Monthly 3	___ Monthly 3
___ Less than Monthly 4	___ Less than Monthly 4	___ Less than Monthly 4
___ Never 5	___ Never 5	___ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

___ No 0 ___ Yes 1

UAI Part B 9

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

___ No 0 ___ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-perscription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?

___ No 0 ___ Yes 1
Describe concerns: _____

Do (did) you ever use alcohol/other mood-altering substances with...

No 0 Yes 1
___ ___ Prescription drugs?
___ ___ OTC medicine?
___ ___ Other substances?

Describe what and how often:

Do (did) you ever use alcohol/other mood-altering substances to help you...

No 0 Yes 1
___ ___ Sleep?
___ ___ Relax?
___ ___ Get more energy?
___ ___ Relieve worries?
___ ___ Relieve physical pain?

Describe what and how often:

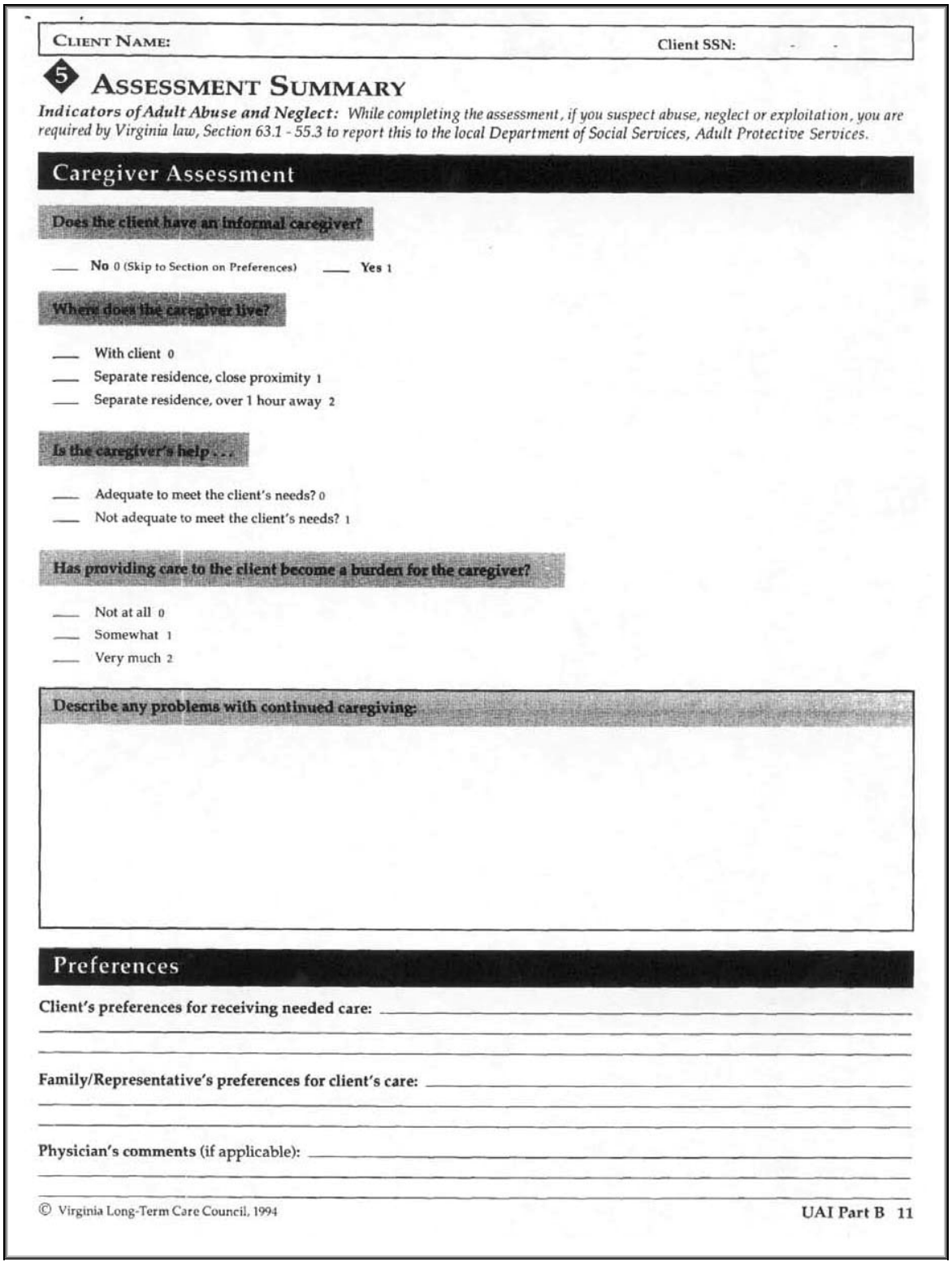
Do (did) you ever smoke or use tobacco products?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

UAI Part B 10

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

___ **No** 0 (Skip to Section on Preferences) ___ **Yes** 1

Where does the caregiver live?

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

Is the caregiver's help . . .

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

___ Not at all 0
___ Somewhat 1
___ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preferences for receiving needed care: _____

Family/Representative's preferences for client's care: _____

Physician's comments (if applicable): _____

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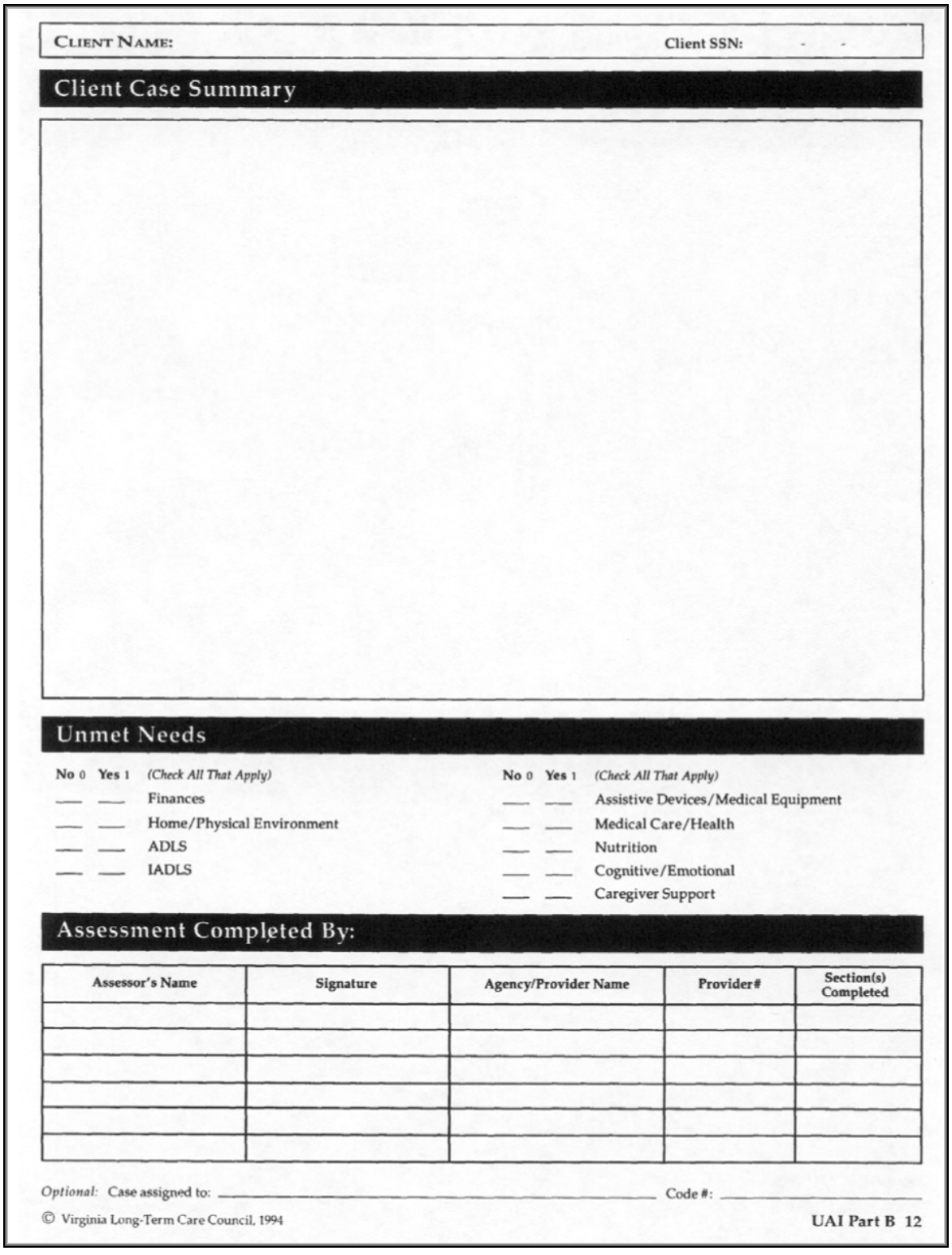
Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Client Case Summary

Unmet Needs

No 0	Yes 1	(Check All That Apply)	No 0	Yes 1	(Check All That Apply)
___	___	Finances	___	___	Assistive Devices/Medical Equipment
___	___	Home/Physical Environment	___	___	Medical Care/Health
___	___	ADLS	___	___	Nutrition
___	___	IADLS	___	___	Cognitive/Emotional
			___	___	Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider#	Section(s) Completed

Optional: Case assigned to: _____ Code #: _____

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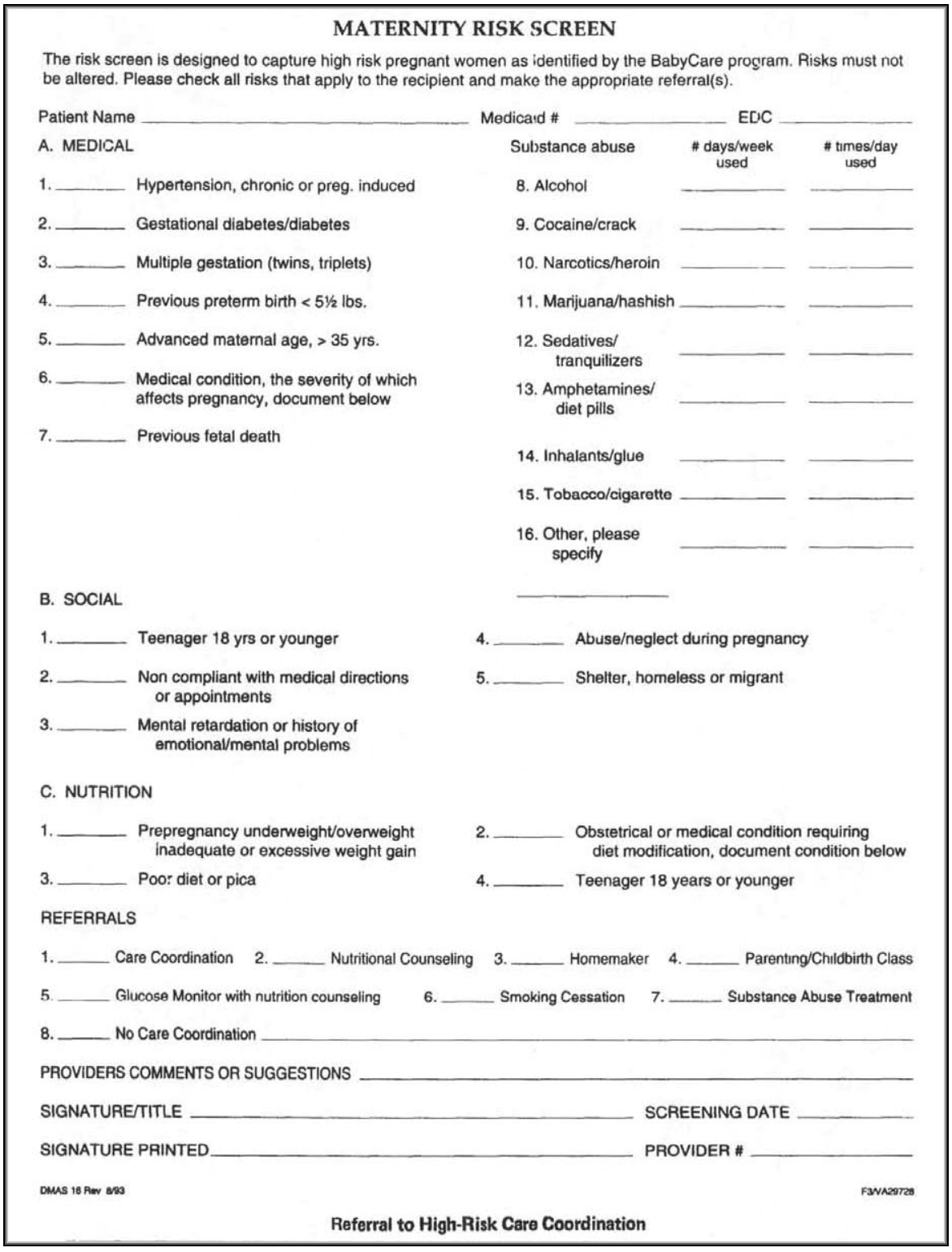
UAI Part B 12

Sample Virginia Uniform Assessment Instrument



MATERNITY RISK SCREEN

The risk screen is designed to capture high risk pregnant women as identified by the BabyCare program. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name _____ Medicaid # _____ EDC _____

A. MEDICAL

1. _____ Hypertension, chronic or preg. induced
2. _____ Gestational diabetes/diabetes
3. _____ Multiple gestation (twins, triplets)
4. _____ Previous preterm birth < 5½ lbs.
5. _____ Advanced maternal age, > 35 yrs.
6. _____ Medical condition, the severity of which affects pregnancy, document below
7. _____ Previous fetal death

Substance abuse	# days/week used	# times/day used
8. Alcohol		
9. Cocaine/crack		
10. Narcotics/heroin		
11. Marijuana/hashish		
12. Sedatives/ tranquilizers		
13. Amphetamines/ diet pills		
14. Inhalants/glue		
15. Tobacco/cigarette		
16. Other, please specify _____		

B. SOCIAL

1. _____ Teenager 18 yrs or younger
2. _____ Non compliant with medical directions or appointments
3. _____ Mental retardation or history of emotional/mental problems
4. _____ Abuse/neglect during pregnancy
5. _____ Shelter, homeless or migrant

C. NUTRITION

1. _____ Prepregnancy underweight/overweight inadequate or excessive weight gain
2. _____ Obstetrical or medical condition requiring diet modification, document condition below
3. _____ Poor diet or pica
4. _____ Teenager 18 years or younger

REFERRALS

1. _____ Care Coordination 2. _____ Nutritional Counseling 3. _____ Homemaker 4. _____ Parenting/Childbirth Class
5. _____ Glucose Monitor with nutrition counseling 6. _____ Smoking Cessation 7. _____ Substance Abuse Treatment
8. _____ No Care Coordination _____

PROVIDERS COMMENTS OR SUGGESTIONS _____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PROVIDER # _____

DMAS 18 Rev 8/93 F3/VA29728

Referral to High-Risk Care Coordination

Sample MICC Maternity Risk Screen

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT RISK SCREEN

Research supports the fact that indigent mothers and their high risk infants often need a combination of medical and non-medical services to assure positive infant health.
The risk screen is designed to capture high risk infants as identified by the Baby Care Program. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name: _____ VMAP ID#_____
Parent /Guardian Name: _____
Patient Address: _____

A. MEDICAL

__Diagnosed developmentally delayed/neurologically impaired

__Diagnosed medically significant genetic condition (including sickle cell disease)

__ Birth Weight 1750 grams (3lbs., 14 oz) or less

__Chronic illness

__Diagnosed with fetal alcohol syndrome (FAS)

__Medical high risk infant and pediatric care needed but not available 24 hours a day

__Medical condition(s) the severity of which requires care coordination (document medical condition below)

__Born exposed to an illegal drug in utero

__Failure to thrive of flattening of growth curve

B. SOCIAL

__Parent/guardian unable to communicate due to language barriers (e.g. non-English speaking, illiterate)

__Maternal absence (illness, incarceration, abandonment)

__Parental substance abuse/addition (only includes father if living in home)

__ Caregiver's handicap presents risk to infant (physical impaired, hearing impaired, vision impaired)

__Caregiver mental illness/mental retardation

__Shelter, homeless or migrant worker

__Mother 18 years or younger

__History of suspected abuse/or neglect

__Non compliant with follow-up visits/screening visits and medical direction for this infant.

C. NUTRITION

__ Congenial abnormalities affecting ability to feed or requiring special feeding techniques; poor sucking, severe or continuing diarrhea or vomiting; other conditions requiring diet modification.

__ Inadequate diet

D. REFERRAL

__Care Coordination

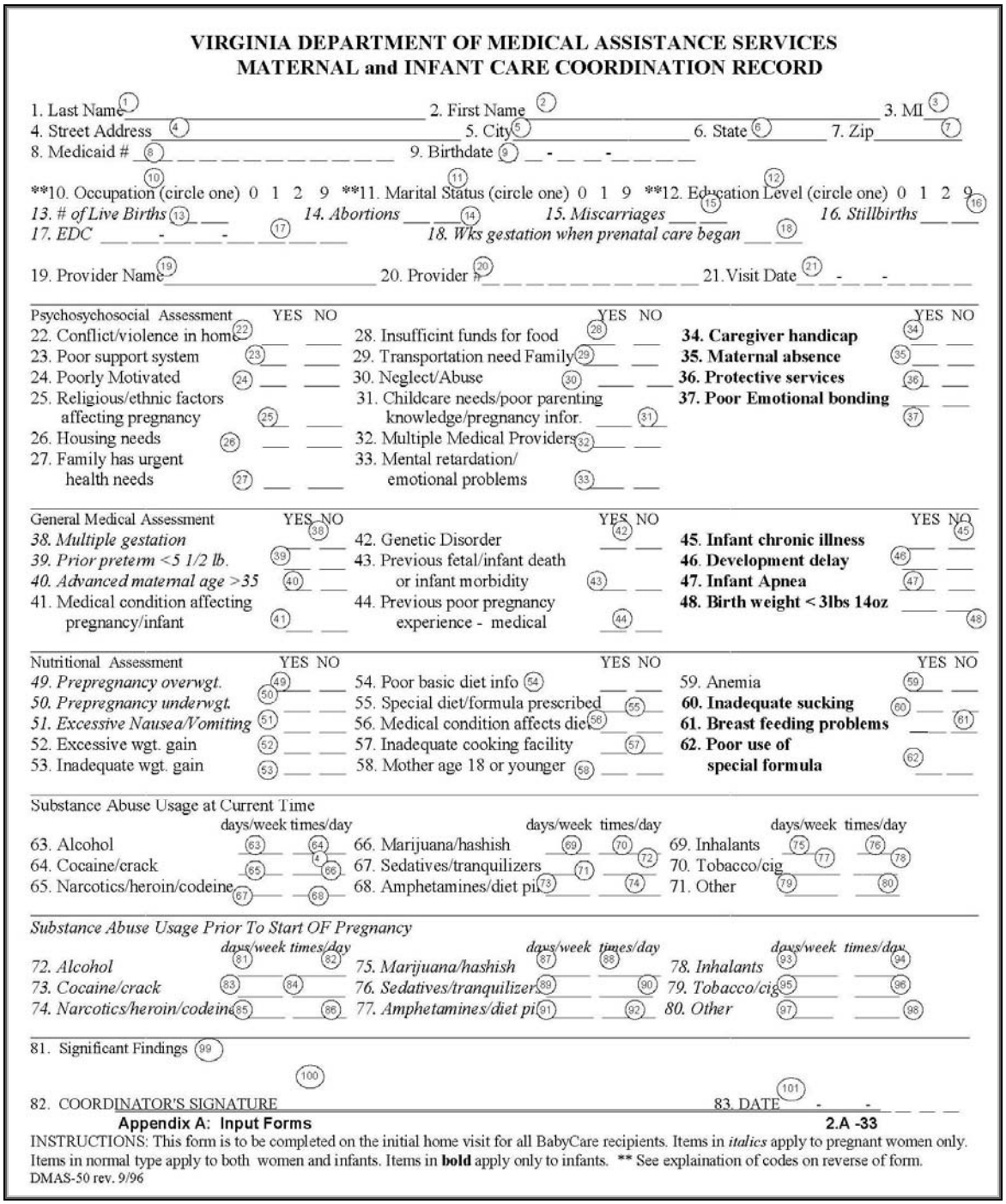
__No Care Coordination - What services will the recipient receive?_____

PROVIDER COMMENTS OR SUGGESTIONS_____

SIGNATURE/TITLE_____SCREENING DATE_____

SIGNATURE PRINTED PROVIDER #

Sample MICC Infant Risk Screen



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL and INFANT CARE COORDINATION RECORD

1. Last Name (1) _____ 2. First Name (2) _____ 3. MI (3) ___
4. Street Address (4) _____ 5. City (5) _____ 6. State (6) _____ 7. Zip (7) _____
8. Medicaid # (8) _ _ _ _ _ _ _ _ _ _ 9. Birthdate (9) _ _ - _ _ - _ _ _ _

**10. Occupation (10) (circle one) 0 1 2 9 **11. Marital Status (11) (circle one) 0 1 9 **12. Education Level (12) (circle one) 0 1 2 9
13. # of Live Births (13) ___ 14. Abortions (14) ___ 15. Miscarriages (15) ___ 16. Stillbirths (16) ___
17. EDC (17) ___ - ___ - ___ ___ ___ 18. Wks gestation when prenatal care began (18) ___

19. Provider Name (19) _____ 20. Provider # (20) _ _ _ _ _ _ _ _ _ _ 21. Visit Date (21) _ _ - _ _ - _ _ _ _

Psychosychosocial Assessment	YES	NO		YES	NO		YES	NO
22. Conflict/violence in home (22)			28. Insufficint funds for food (28)			**34. Caregiver handicap (34)**		
23. Poor support system (23)			29. Transportation need Family (29)			**35. Maternal absence (35)**		
24. Poorly Motivated (24)			30. Neglect/Abuse (30)			**36. Protective services (36)**		
25. Religious/ethnic factors affecting pregnancy (25)			31. Childcare needs/poor parenting knowledge/pregnancy infor. (31)			**37. Poor Emotional bonding (37)**		
26. Housing needs (26)			32. Multiple Medical Providers (32)					
27. Family has urgent health needs (27)			33. Mental retardation/ emotional problems (33)					

General Medical Assessment	YES	NO		YES	NO		YES	NO
38. Multiple gestation (38)			42. Genetic Disorder (42)			**45. Infant chronic illness (45)**		
39. Prior preterm <5 1/2 lb. (39)			43. Previous fetal/infant death or infant morbidity (43)			**46. Development delay (46)**		
40. Advanced maternal age >35 (40)						**47. Infant Apnea (47)**		
41. Medical condition affecting pregnancy/infant (41)			44. Previous poor pregnancy experience - medical (44)			**48. Birth weight < 3lbs 14oz (48)**		

Nutritional Assessment	YES	NO		YES	NO		YES	NO
49. Prepregnancy overwgt. (49)			54. Poor basic diet info (54)			59. Anemia (59)		
50. Prepregnancy underwgt. (50)			55. Special diet/formula prescribed (55)			**60. Inadequate sucking (60)**		
51. Excessive Nausea/Vomiting (51)			56. Medical condition affects diet (56)			**61. Breast feeding problems (61)**		
52. Excessive wgt. gain (52)			57. Inadequate cooking facility (57)			**62. Poor use of special formula (62)**		
53. Inadequate wgt. gain (53)			58. Mother age 18 or younger (58)					

Substance Abuse Usage at Current Time

	days/week	times/day		days/week	times/day		days/week	times/day
63. Alcohol (63) (64)			66. Marijuana/hashish (69) (70)			69. Inhalants (75) (76)		
64. Cocaine/crack (65) (66)			67. Sedatives/tranquilizers (71) (72)			70. Tobacco/cig (77) (78)		
65. Narcotics/heroin/codeine (67) (68)			68. Amphetamines/diet pi (73) (74)			71. Other (79) (80)		

Substance Abuse Usage Prior To Start OF Pregnancy

	days/week	times/day		days/week	times/day		days/week	times/day
72. Alcohol (81) (82)			*75. Marijuana/hashish (87) (88)*			*78. Inhalants (93) (94)*		
73. Cocaine/crack (83) (84)			*76. Sedatives/tranquilizer (89) (90)*			*79. Tobacco/cig (95) (96)*		
74. Narcotics/heroin/codeine (85) (86)			*77. Amphetamines/diet pi (91) (92)*			*80. Other (97) (98)*		

81. Significant Findings (99)

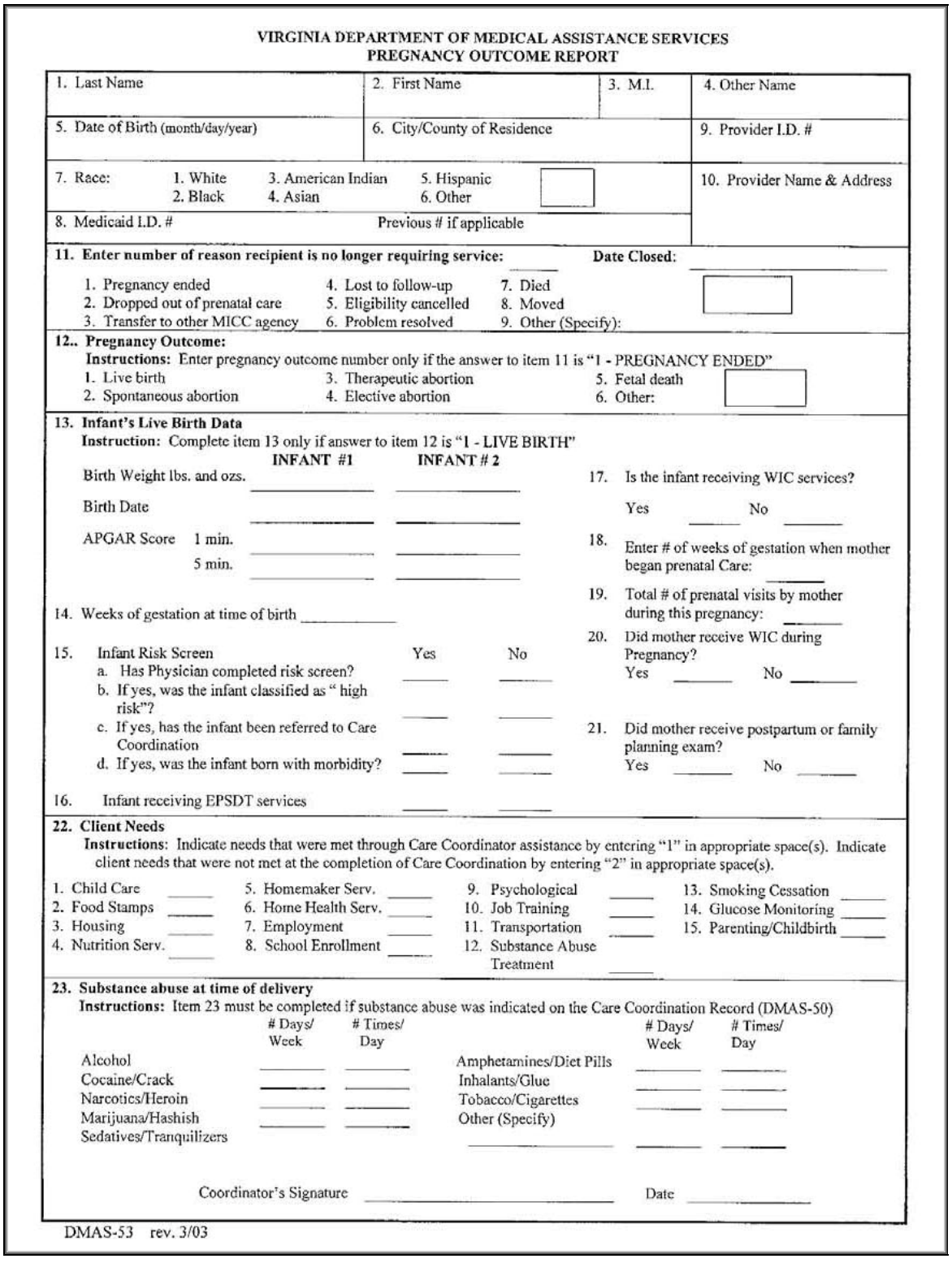
(100)

82. COORDINATOR'S SIGNATURE _____ 83. DATE (101) _ _ - _ _ - _ _ _ _

Appendix A: Input Forms **2.A -33**

INSTRUCTIONS: This form is to be completed on the initial home visit for all BabyCare recipients. Items in *italics* apply to pregnant women only. Items in normal type apply to both women and infants. Items in **bold** apply only to infants. ** See explaination of codes on reverse of form.
DMAS-50 rev. 9/96

Sample VDMAS Maternal and Infant Care Coordination Record



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PREGNANCY OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (month/day/year)	6. City/County of Residence		9. Provider I.D. #
7. Race: 1. White 2. Black 3. American Indian 4. Asian 5. Hispanic 6. Other			10. Provider Name & Address
8. Medicaid I.D. # Previous # if applicable			

11. Enter number of reason recipient is no longer requiring service: ____ **Date Closed:** _____

1. Pregnancy ended
2. Dropped out of prenatal care
3. Transfer to other MICC agency
4. Lost to follow-up
5. Eligibility cancelled
6. Problem resolved
7. Died
8. Moved
9. Other (Specify):

12.. Pregnancy Outcome:
Instructions: Enter pregnancy outcome number only if the answer to item 11 is "1 - PREGNANCY ENDED"

1. Live birth
2. Spontaneous abortion
3. Therapeutic abortion
4. Elective abortion
5. Fetal death
6. Other:

13. Infant's Live Birth Data
Instruction: Complete item 13 only if answer to item 12 is "1 - LIVE BIRTH"

	INFANT #1	INFANT # 2
Birth Weight lbs. and ozs.		
Birth Date		
APGAR Score 1 min.		
5 min.		

14. Weeks of gestation at time of birth _____

15. Infant Risk Screen	Yes	No
a. Has Physician completed risk screen?		
b. If yes, was the infant classified as " high risk"?		
c. If yes, has the infant been referred to Care Coordination		
d. If yes, was the infant born with morbidity?		
16. Infant receiving EPSDT services		

17. Is the infant receiving WIC services?
Yes _____ No _____

18. Enter # of weeks of gestation when mother began prenatal Care: _____

19. Total # of prenatal visits by mother during this pregnancy: _____

20. Did mother receive WIC during Pregnancy?
Yes _____ No _____

21. Did mother receive postpartum or family planning exam?
Yes _____ No _____

22. Client Needs
Instructions: Indicate needs that were met through Care Coordinator assistance by entering "1" in appropriate space(s). Indicate client needs that were not met at the completion of Care Coordination by entering "2" in appropriate space(s).

1. Child Care
2. Food Stamps
3. Housing
4. Nutrition Serv.
5. Homemaker Serv.
6. Home Health Serv.
7. Employment
8. School Enrollment
9. Psychological
10. Job Training
11. Transportation
12. Substance Abuse Treatment
13. Smoking Cessation
14. Glucose Monitoring
15. Parenting/Childbirth

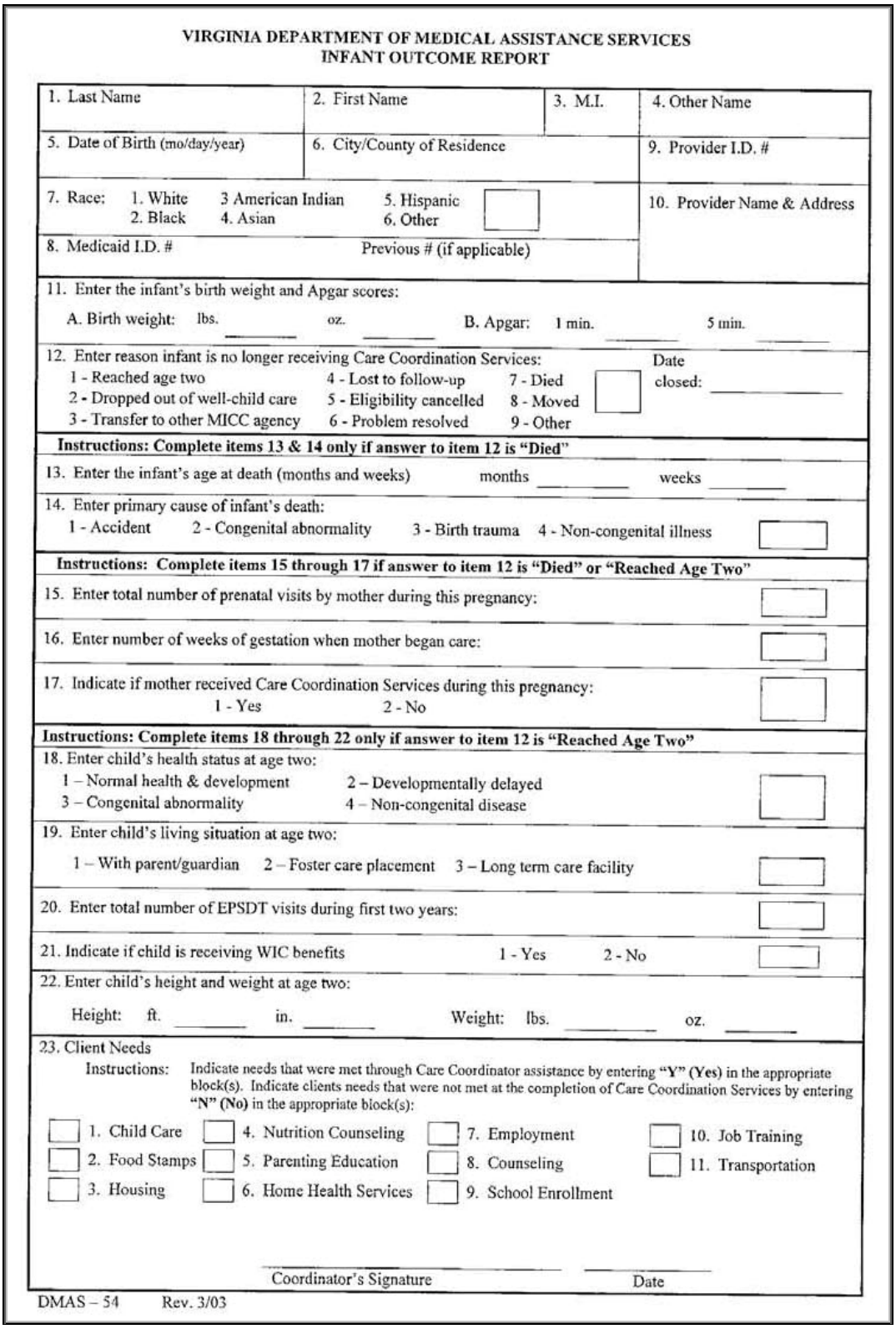
23. Substance abuse at time of delivery
Instructions: Item 23 must be completed if substance abuse was indicated on the Care Coordination Record (DMAS-50)

	# Days/ Week	# Times/ Day		# Days/ Week	# Times/ Day
Alcohol			Amphetamines/Diet Pills		
Cocaine/Crack			Inhalants/Glue		
Narcotics/Heroin			Tobacco/Cigarettes		
Marijuana/Hashish			Other (Specify)		
Sedatives/Tranquilizers					

Coordinator's Signature _____ Date _____

DMAS-53 rev. 3/03

Sample VDMAS Pregnancy Outcome Report



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (mo/day/year)	6. City/County of Residence		9. Provider I.D. #
7. Race: 1. White 2. Black 3 American Indian 4. Asian 5. Hispanic 6. Other			10. Provider Name & Address
8. Medicaid I.D. # Previous # (if applicable)			

11. Enter the infant's birth weight and Apgar scores:
A. Birth weight: lbs. _____ oz. _____ B. Apgar: 1 min. _____ 5 min. _____

12. Enter reason infant is no longer receiving Care Coordination Services: Date closed: _____
1 - Reached age two; 2 - Dropped out of well-child care; 3 - Transfer to other MICC agency; 4 - Lost to follow-up; 5 - Eligibility cancelled; 6 - Problem resolved; 7 - Died; 8 - Moved; 9 - Other

Instructions: Complete items 13 & 14 only if answer to item 12 is "Died"

13. Enter the infant's age at death (months and weeks) months _____ weeks _____

14. Enter primary cause of infant's death:
1 - Accident 2 - Congenital abnormality 3 - Birth trauma 4 - Non-congenital illness

Instructions: Complete items 15 through 17 if answer to item 12 is "Died" or "Reached Age Two"

15. Enter total number of prenatal visits by mother during this pregnancy:

16. Enter number of weeks of gestation when mother began care:

17. Indicate if mother received Care Coordination Services during this pregnancy:
1 - Yes 2 - No

Instructions: Complete items 18 through 22 only if answer to item 12 is "Reached Age Two"

18. Enter child's health status at age two:
1 – Normal health & development 2 – Developmentally delayed
3 – Congenital abnormality 4 – Non-congenital disease

19. Enter child's living situation at age two:
1 – With parent/guardian 2 – Foster care placement 3 – Long term care facility

20. Enter total number of EPSDT visits during first two years:

21. Indicate if child is receiving WIC benefits 1 - Yes 2 - No

22. Enter child's height and weight at age two:
Height: ft. _____ in. _____ Weight: lbs. _____ oz. _____

23. Client Needs
Instructions: Indicate needs that were met through Care Coordinator assistance by entering **"Y" (Yes)** in the appropriate block(s). Indicate clients needs that were not met at the completion of Care Coordination Services by entering **"N" (No)** in the appropriate block(s):

1. Child Care; 2. Food Stamps; 3. Housing; 4. Nutrition Counseling; 5. Parenting Education; 6. Home Health Services; 7. Employment; 8. Counseling; 9. School Enrollment; 10. Job Training; 11. Transportation

_____ Coordinator's Signature _____ Date

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Sample VDMAS Infant Outcome Report

Appendix B TADs

Forms in this Appendix	
Form Name	**Page**
AS-O-111 – TAD Error Correction Cover Letter – CBC	87

(2) _____

_____ (3)
_____ (4)
_____ (5)

(6) (7) (8)

(1)
ACN # _____

Enrollee Name: _____ (9)
Enrollee ID #: _____ (10)
Assessment Date: _____ (11)
Medicaid Auth: _____ (12)

Recently, a screening assessment form was submitted for processing. However, after careful review of the form, it has been determined that certain data elements were either missing, inappropriate, or incomplete.

Please make the necessary corrections to the items listed on the attached turnaround document and return the entire package, along with this letter, to the address listed below within five (5) working days of the receipt of this letter. The following items that require corrections are marked with double asterisks (**) on the attached turnaround document.

First Health Services
Post Office Box 85083
Richmond, Virginia 23285-5079

SPECIAL NOTE: Any questions regarding the submission of this information or any other related issue must be directed to the [redacted]

ACN # _____

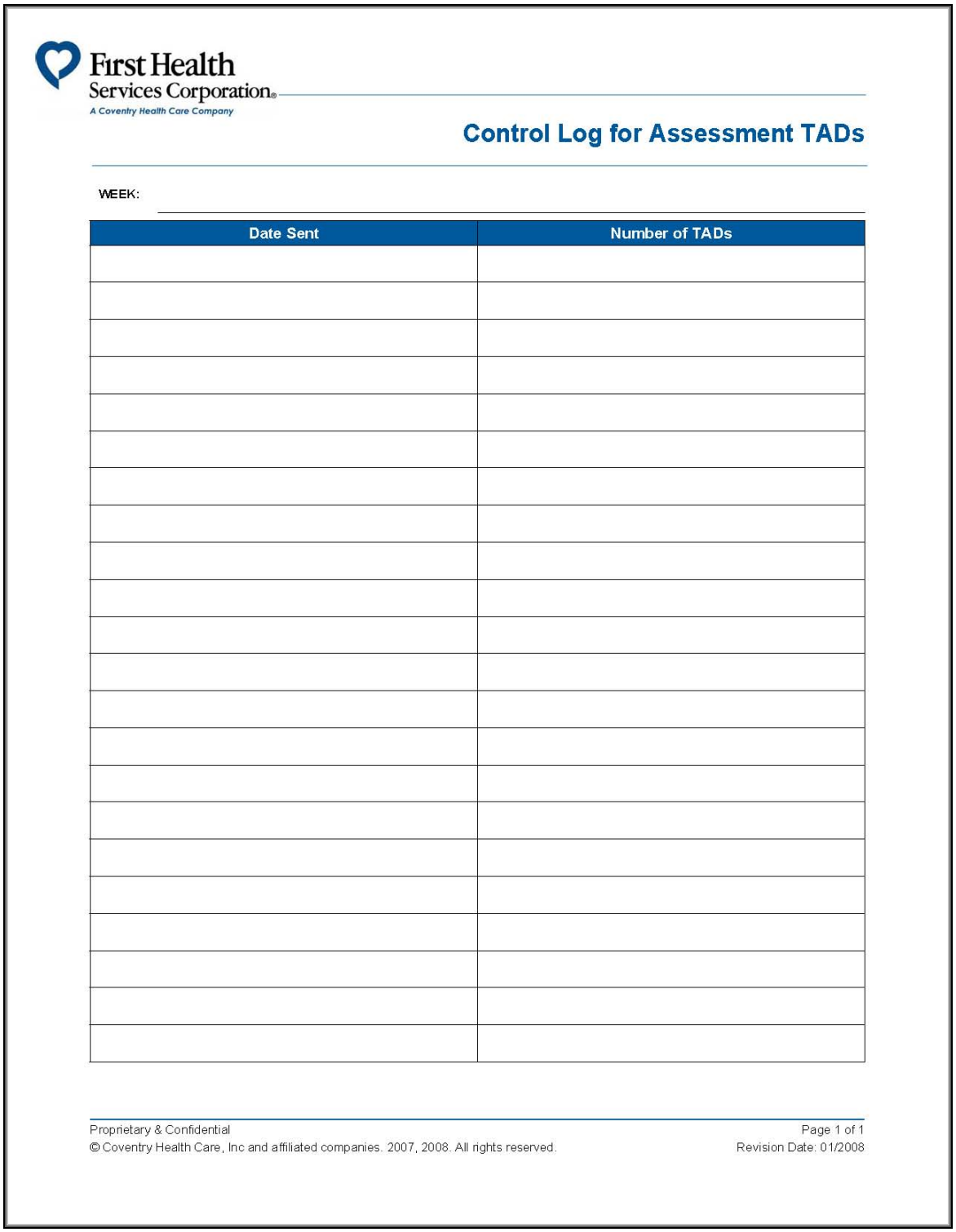
Error Messages Below

(13)
[*Sample system-generated error messages below*]
[1. *Physical Environment – Where do you usually live?*]
[2. *Functional Status – ADLS Bathing*]
[3. *How Do You Take Your Medicine?*]

Sample AS-O-111 – TAD Error Correction Cover Letter - CBC

Appendix C TAD Control Log

Forms in this Appendix	
Form Name	**Page**
TAD Control Log	88



First Health Services Corporation
A Coventry Health Care Company

Control Log for Assessment TADs

WEEK: _____

Date Sent	Number of TADs

Sample TAD Control Log